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ABSTRACT

This teacher's edition contains curriculum materials for an upgrading course for medication administration technicians who have completed initial training. The course consists of six units of instruction that cover the following: (1) controlling infection; (2) administering medication; (3) obtaining vital signs; (4) discussing legal issues and residents' rights; (5) preparing for medical emergencies; and (6) charting medication administration and resident care. Each unit contains some or all of the following components: objective sheet, instructor's guide, information sheet, assignment sheet, job sheet and skill test record, written test, and answers to the written test. Units are designed to be used for more than one class period. (KC)

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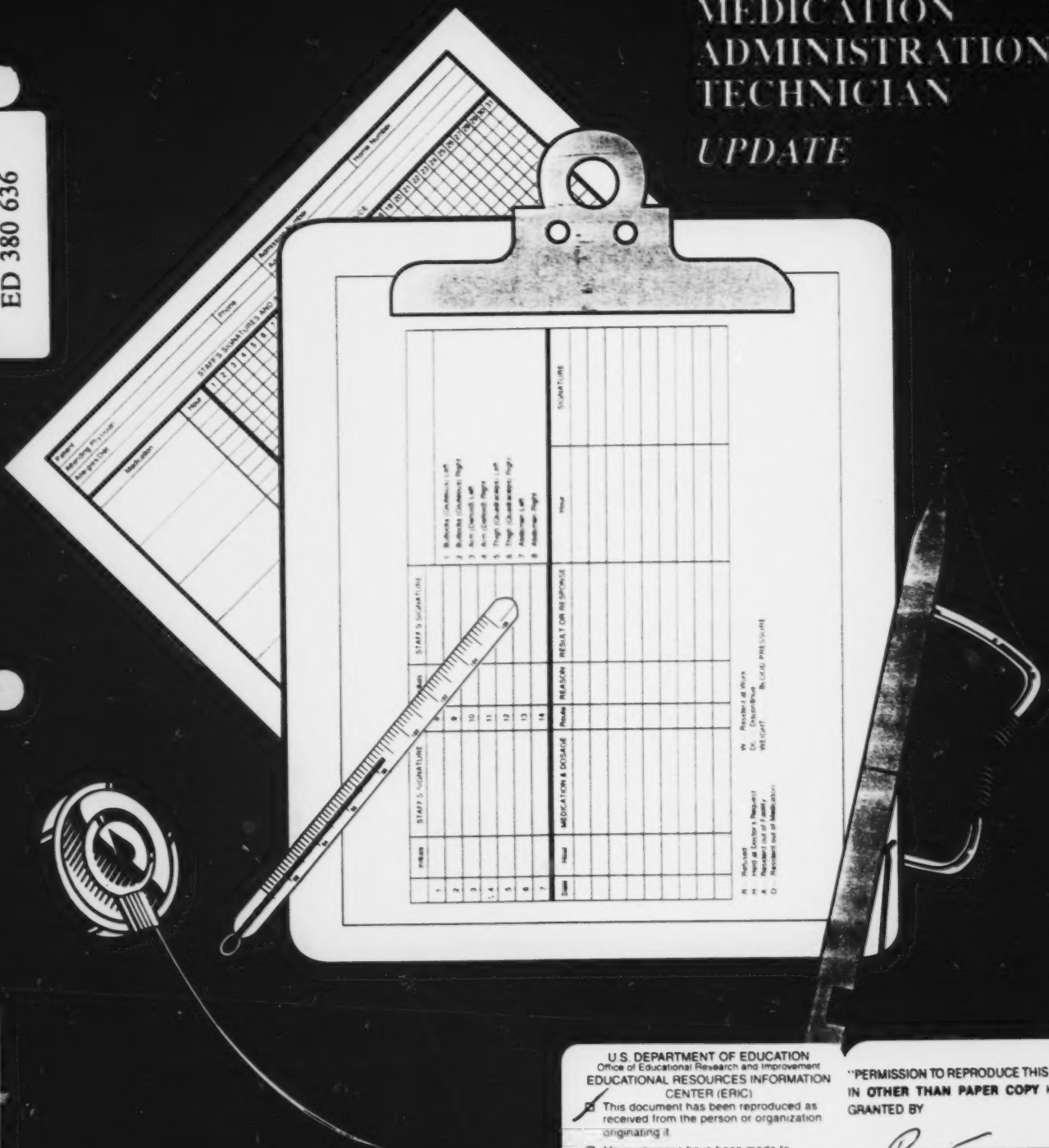
ED 380 636

MEDICATION ADMINISTRATION TECHNICIAN

UPDATE



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CIMC

Teacher Edition

Oklahoma Department of Vocational and Technical Education
1500 West Seventh Avenue
Stillwater, OK 74074-4364

92-008910

AD 1141

MEDICATION ADMINISTRATION TECHNICIAN

Update

Teacher Edition

Developed by the
Curriculum and Instructional Materials Center,
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92-008910

AD 1141

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FOREWORD

This *Medication Administration Technician Update* curriculum will help you satisfy your legal requirement for 8 hours of annual training. It will also allow you to review, reinforce, and build upon the skills that you developed in your original MAT training program.

The Oklahoma Department of Vocational and Technical Education has worked closely with professionals representing residential care, group homes, the Oklahoma State Department of Health, and the Oklahoma Department of Human Services, to develop these instructional materials.

Students who successfully complete this training can take pride in knowing that they are among the best-trained professionals in the field. The Oklahoma Department of Vocational and Technical Education is proud to assist you in meeting your training requirement.

Roy Peters, Jr.,
State Director
Oklahoma Department of Vocational
and Technical Education

ACKNOWLEDGEMENTS

ADVISORY COMMITTEE

Pat Bodkin
Special Health Services Division,
Oklahoma State Department of Health

Effie Foster
Oklahoma Production Center
Center for DD., Inc.

Edna Keaton
Edna Lee's Residential Care

Anne Reinschmiedt
Lakeview Lodging

Shirley Ryan

Dolores Sutton
Mid-Del Group Homes, Inc.

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Thank you to everyone involved.

Craig A. Maile
Curriculum Specialist

USE OF THIS PUBLICATION

INSTRUCTIONAL UNITS

Each instructional unit includes basic components that form a unit of instruction: performance objectives, suggested activities, information sheets, supplements, assignment sheets, job sheets, practical tests, written tests, and written test answers. Practical tests and written tests are included in the instructor edition only, and may be duplicated for classroom use or copies may be purchased in Oklahoma by calling 800-522-5810. Out-of-state instructors may order test packets by calling 800-654-4502.

All of the unit components focus on measurable and observable learning outcomes. Instructors are encouraged to supplement, personalize, localize, and motivate with these materials in order to develop a complete teaching/learning process.

Objective Sheets

Each unit of instruction is based on performance objectives. Performance objectives are stated in two forms: unit objectives, stating the subject matter to be covered in a unit of instruction, and specific objectives, stating the performance necessary to meet the unit objective.

The unit objective states the overall goal of the unit. It tells what the student should be able to do and what standard will be used to determine whether the student has achieved competency. Specific objectives outline the teaching sequence of the competencies required to meet the unit objective.

Instructors can also use the objectives to plan teaching strategies and instructional methods. Instructors should prepare for each unit by deciding how each objective can best be taught.

Suggested Activities — Instructor's Edition Only

The Suggested Activities component is to assist the instructor during the preparation stage of the teaching/learning process. The activities provide suggestions for delivery, application, and evaluation during the instructional process. Teaching suggestions are included for each objective. The instructor should read the suggested activities before teaching the units to allow time to obtain supplemental materials, prepare audiovisual materials, and contact outside resource persons. Duties of the instructor will vary according to the particular unit.

Listed are suggested resources including people and print and non-print media that may be used to teach the unit. Unit references used in the development of each unit are also provided. The instructor can use suggested resources and unit references to supplement knowledge of the subject or to help students with particular interests or objectives in the area covered. Please note that suggested resources and references listed in this publication existed when this publication was written. CIMC assumes no responsibility for providing these materials and cannot ensure the availability of these materials as individual vendors, manufacturers, and publishers may discontinue these products at any time.

Information Sheet

The Information Sheets provide "must know" content that is essential for meeting the cognitive objectives. The Information Sheets serve as an excellent guide for presenting background knowledge necessary to develop the skills specified in the unit objective. They may also be used for coordination activities and advisory committee meetings.

Students should read the Information Sheets before the information is discussed in class. Space is provided in margins for students and instructors to add notes that supplement, localize, personalize, or provide motivation for each unit.

The Information Sheets may include notes, cautions, or warnings. These should be discussed carefully and thoroughly. Notes are short verbal additions to the information or procedural outline that provide nice-to-know and decision-making information. A note may tell the student what to look for or consider at a given step, or may explain when a step may not be applicable. Notes offer guidance that may help the student understand the process and accomplish it more efficiently. Warnings are advisories that alert the student to possible danger to himself or herself or others. Cautions are advisories that alert students to possible danger to equipment or facilities.

Supplements

Supplements include instructions that could be used for solving a problem or reinforcing the enrichment of learning. While supplements are not tested over directly, they may be used to assist in arriving at solutions using cognitive knowledge and higher-order thinking skills. They provide additional information for understanding the topic but may not have direct application to specific objectives.

Assignment Sheets

The Assignment Sheets in *Medication Administration Technician Update* are supplementary activities only. Students are not required to achieve a particular score on any Assignment Sheet in order to successfully complete any given unit. The Assignment Sheets are also not a part of the Written Test for any unit.

Job Sheets

Job Sheets provide a list of equipment, tools, and materials needed to complete a manipulative or psychomotor skill. They describe a step-by-step procedure to complete each task or job. The instructor should demonstrate the procedures outlined in each Job Sheet. Furthermore, the instructor must localize the procedure according to the equipment and supplies available locally.

Practical Tests — Instructor's Edition Only

The Practical Tests assist the instructor in evaluating the psychomotor activities (Job Sheets). The Practical Tests provide instructors with a valid mechanism for determining a student's level of ability to perform the procedure stated on the Job Sheet and provide the instructor with a means of evaluating the final product.

Written Tests — Instructor's Edition Only

This component provides criterion-referenced evaluation of every objective listed in the unit of instruction. All performance objectives, including those in the Information Sheets and Job Sheets, must be evaluated. If objectives have been added, deleted, or modified, appropriate changes should be made on the test.

The tests may be written or oral. It is recommended that the tests be divided into shorter tests covering three or four objectives at a time and given soon after those objectives have been covered.

The acceptable response on a written test, eighty-five percent (85%) in most units, may be raised or lowered to fit the topic or student ability level. The percentage applies to the overall score, not to each individual question. The final unit grade should be obtained by combining written test scores and by considering how well the student demonstrated the desired skills.

Assignment Answers and Written Test Answers — Instructor's Edition Only

These components are designed to assist the instructor in evaluating student performance.

BASIC SKILLS IN CIMC MATERIALS

Preparing students to enter successfully into today's world of work offers vocational education a substantial challenge. The contemporary workplace is characterized by constant and rapid technological change and by increasing job complexity and skill intensity. Due to rapid technological advancement, the half-life of work skills is now reduced to a bare three to five years. Out of this new workplace environment has arisen a growing awareness of the critical importance of an American workforce armed with the skills necessary to survive in a competitive economy.

One result of this national awareness has been the emergence of a renewed emphasis on basic academic skills in all areas of education. Pressure to increase academic skill development is being placed on education by both legislative action and industry mandate. The Carl D. Perkins Vocational and Applied Technology Education Act of 1990 sets stringent basic skill requirements for vocational education. State legislatures are increasingly requiring basic skills accountability by teachers and school administrators. Graduation exams, minimum competency requirements, and expected learner outcomes are being implemented with increasing frequency. In addition, business and industry are delivering the message clearly to educators that vocational competence now requires increased strength in the basic skills.

The issue of the basic skills currently required in the workplace was very successfully addressed in a recent national three-year study conducted jointly by the American Society of Training and Development (ASTD) and the U.S. Department of Labor (DOL). The findings of this study were published in 1990 in the book, *Workplace Basics: The Essential Skills Employers Want.*

The ASTD/DOL research indicates clearly that American employers have discovered that their workforces need a variety of skills that include, but are not limited to, the classic academic trio of reading, writing, and computation. Employers now are also looking for competence in areas such as "learning to learn," problem solving and critical thinking, interpersonal and teamwork skills, oral communication and listening techniques, and the social and personal management skills that demonstrate a capacity for independence and responsibility in on-the-job performance.

It is clear that the requirements of today's business and industry have expanded and re-defined "workplace basics." It is in line with this re-definition and with the competency requirements of current education legislation, that the Oklahoma Department of Vocational and Technical Education has chosen to address "basic skills" in the instructional materials produced by its Curriculum and Instructional Materials Center.

It is not a new development for CIMC materials to contain information and activities which develop basic skills competencies in students undertaking vocational programs. What is new is the specific marking, or flagging, of items in our instructional materials that address basic skills.

To assist teachers and students in identifying activities which promote basic skills development, CIMC has implemented a marking system which uses simple graphic symbols or icons. These icons are located in the left margins of assignment sheets, activity sheets, and job sheets. The following is an explanation of the icons and the kinds of basic skill activities they indicate.

1. **READING SKILLS:** Skills involving use of print resource material for obtaining and applying information.

Current vocational education literature indicates that functional literacy as a workplace basic needs to be defined in terms of reading competencies actually required for job performance. The activities identified with this icon addressing reading skills in CIMC materials deal specifically with developing reading skills in an applied, job-related context. These range from general information-gathering activities to tasks requiring use of specific technical reference materials. Many contain a "learning to learn" aspect which promotes engaging actively and purposefully in vocationally relevant inquiry.

2. **WRITING SKILLS:** Skills involving written communication of processes, information, or ideas.

Tasks identified with this icon promote development of skills in written communications. As with reading skills, the writing skills emphasized in CIMC materials have a vocational context. They include filling out forms, keeping work activity records, writing simple memos and letters, generating more complex reports and articles, and written expression of ideas and concepts related to vocational performance or exploration.

3. **MATHEMATICS SKILLS:** Skills involving computation, calculation, and interpretation of numerical data.

This icon identifies activities which develop vocationally-related skills in computing, measuring and estimating, selecting and applying appropriate mathematical processes, and collecting, displaying, or interpreting data.

4. **SCIENCE SKILLS:** Skills involving mastery and application of scientific information or theory.

This icon marks activities which are related to the development of skills in either the physical or biological sciences. These skills stress occupationally-related application of science and technology.

5. **ORAL COMMUNICATION SKILLS:** Skills involving speaking and listening.

Activities marked with this icon promote development of effective speaking and listening. They include practice in such areas as speaking techniques, word choice, non-verbal messages, use of communication media, and using active listening techniques. Many of these activities promote "learning to learn" skills in verbal inquiry.

6. **INTERPERSONAL OR RELATING SKILLS:** Skills involving working and getting along with others.

Activities which deal directly with skills in relating to others are marked with this icon. This includes areas such as multi-cultural awareness, group processes and dynamics, negotiation, dealing with conflict, cooperation and teamwork, values and attitudes, and leadership and motivation.

7. **CREATIVE THINKING AND PROBLEM SOLVING SKILLS:** Skills involving comprehending, applying, analyzing, and developing complex ideas and situations.

This icon identifies activities which stress development of higher-order thought processes such as problem identification and analysis, lateral thinking, evaluating alternatives, developing solutions, examining assumptions, and evaluating outcomes.

8. **EMPLOYABILITY SKILLS:** Skills involving choosing, obtaining, and succeeding in a career.

Activities marked with this icon relate to competencies required to obtain employment and develop a career. These competencies include specific occupational tasks. They also include items such as career analysis and selection, job searching, completing applications and resumes, interviewing, business etiquette, and personal management skills required for job-keeping and maturing in one's work. Examples of the latter category include personal presentation, self-discipline, work accuracy, reliability, discretion, punctuality, handling stress, judgment, confidence, etc.

9. **SOCIAL STUDIES SKILLS:** Skills involving investigation and application of social concepts.

This icon marks activities which stress competencies in fields relating to human society and its distribution and relationships. This includes areas such as history, geography, demographics, current events, cross-cultural studies, consumer issues, environmental issues, and ethical concerns in science and technology.

Some activities in CIMC materials develop skills in more than one of the nine basic skill areas. In cases where the relative strengths of the skill elements are clearly discernable, the identification icon used is the one judged to be the primary, or strongest, element in the activity. For some activities, more than one icon is used, indicating equal strength of basic skills components in the activity.

Once the **general** basic skill activity has been identified by an icon, the CIMC takes the process one step further by indicating the **specific** skills which are addressed in an activity. This is accomplished through the use of enabling objectives, or "enablers."

Lists of enablers, or specific skills required for each activity, have been developed for each of the nine basic skill areas, and have been grouped into sets of related skills under each icon. The list of general categories under each icon is as follows:

1. **Reading Enablers**
Reading Comprehension Skills
Research and Reference Skills
Functional Reading Skills

2. **Writing Enablers**
Language Skills
Composition Skills
Research Skills
Functional Writing Skills

3. **Math Enablers**
Operation and Calculation Skills
Math Application Skills
Data Analysis and Display Skills
Functional Math Skills

4. **Science Enablers**
General Science Skills
Life Science Skills
Physical Science Skills
Earth Science Skills

5. **Oral Communication Enablers**
Oral Presentation Skills
Listening Skills
Interactive Communication Skills

6. **Interpersonal or Relating Enablers**
General Relating Skills
Teamwork/Cooperative Skills
Leadership/Influencing Skills

7. **Creative Thinking/Problem Solving Enablers**
Cognitive Activities Skills

8. **Employability Enablers**
Job Search/Selection Skills
Job Acquisition/Development Skills

9. **Social Studies Enablers**
Information Analysis Skills
Social Studies Application Skills
Functional Social Studies Skills

Applicable enablers and their general categories are listed beneath each icon in the left-hand margin.

The use of graphic icons to identify basic skills in CIMC instructional materials is the first in a series of steps designed to foster basic skills development in vocational students and accountability for vocational teachers. The Oklahoma Department of Vocational and Technical Education has developed a staged implementation strategy for integrating basic skills into CIMC materials. Additional basic skill elements in future CIMC publications will reflect the advancement of this staged implementation.

Development Coordinator
Curriculum and Instructional
Materials Center
Oklahoma Department of Vocational
and Technical Education
1500 West Seventh Avenue
Stillwater, Oklahoma 74074-4364

CONTENTS

Unit Name	Page
UNIT 1 Control Infection	1-1
UNIT 2 Administer Medication	2-1
UNIT 3 Obtain Vital Signs	3-1
UNIT 4 Discuss Legal Issues and Residents' Rights	4-1
UNIT 5 Prepare for Medical Emergencies	5-1
UNIT 6 Chart Medication Administration and Resident Care	6-1

CORRECTIONS AND SUGGESTIONS

The Curriculum and Instructional Materials Center (CIMC) wants to provide vocational instructors and students with materials that are accurate and effective. Although the CIMC strives to maintain the highest standards of development and production, oversights occasionally do occur. If you find any errors in this or other CIMC publications, or have suggestions for improving their usefulness in vocational programs, please notify the CIMC staff. One easy way of pointing out errors is to make a photocopy of the affected page to indicate the correction on the copy. Mail this information to the CIMC, where it will be used to correct the publication before the materials are reprinted.

To ensure that the material is updated on a timely basis, notify the CIMC of necessary corrections as soon as possible after discovering the error. Do not assume that someone else will notice the error and inform the CIMC; other users may be making the same assumption. Please send corrections and suggestions for improving this publication to the following address:

Curriculum and Instructional Materials Center
Oklahoma Department of Vocational and
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1500 West Seventh Avenue
Stillwater, Oklahoma 74074-4364

OBJECTIVE SHEET	**CONTROL INFECTION** 1
INTRODUCTION	Infections result from disease-causing microorganisms that enter the body. Health care facilities and the responsibilities of the MAT provide many opportunities for infections to be transmitted from one person to another. As a MAT, you can help prevent most infections by following basic guidelines for personal hygiene and good housekeeping. It is easier to prevent an infection than to treat one.
UNIT OBJECTIVE	After completing this unit, you will be familiar with types of microorganisms that can cause infection. You will also learn guidelines and precautions that can help prevent infection. You will demonstrate these competencies by completing a Job Sheet and by completing the Written Test with a minimum of eighty-five percent (85%) accuracy.
PREREQUISITES	Before studying this unit, you should have successfully completed the *Medication Administration Technician* training program.
SPECIFIC OBJECTIVES	After completing this unit, you will be able to 1. Match terms associated with infection control to their correct definition. 2. Distinguish among types of microbes that can cause an infection. 3. Describe the links in the "chain of infection." 4. List common ways that microbes can spread infection. 5. Select from a list guidelines for preventing infection through good personal hygiene. 6. Select from a list guidelines for preventing infection through good housekeeping. 7. State special precautions relating to blood spills/body fluids. 8. Properly wash your hands. (Job Sheet 1)

PREPARATION

- Order additional materials to supplement this unit.
  - — Charts or posters showing microorganisms that can cause infection
  - — Charts or posters showing the importance of good personal hygiene
- Review the unit and plan your presentation:
  - — Estimate the amount of material that can be covered in each class session.
  - — Identify objectives that you can supplement with other resources.
  - — Invite guest speakers in advance.
- Design transparencies and handouts to reinforce the objectives in each unit, to provide additional information, or to facilitate in-class activities.
- Arrange for any needed equipment and materials for student practice.

DELIVERY

Objective 1

- Discuss each of the terms.

Objective 2

- Discuss the types of microbes. Illustrate each type with charts or posters, if available.

Objective 3

- Describe a scenario in a care facility. Describe each of the links in the chain.
- Give examples of ways to break each of the links in the chain.

Objective 4

- Ask for other examples.
- Discuss the number of opportunities for the transmission of infections at a care facility every day.

Objectives 5 and 6

- Explain the importance of each guideline.
- Illustrate this objective with charts or posters, if available
- Demonstrate the correct way to wash hands. Introduce Job Sheet 1.

Objective 7

- Give examples of possible situations and correct responses of the MAT.
- Show examples of items listed, if possible.

APPLICATION

Objective 8

- Demonstrate the procedures for each Job Sheet.
- Have students practice each Job Sheet until they are ready to be evaluated on the Practical Test for each Job Sheet procedure.
- Schedule students for taking Practical Tests.

EVALUATION

Practical Test

- Explain to students that they will be asked to demonstrate procedures on the Job Sheets to complete the Practical Tests.
- Describe the rating scale used on the Practical Test.
- Reteach and retest as necessary.
- Counsel students individually on the results of their Practical Tests.

Written Test

- Give the Written Test soon after presenting the unit.
- Remind students throughout your presentation that the questions and required performance on each Written Test match the Specific Objectives stated at the beginning of the unit and the objectives discussed in the unit.
- Review individual and group performance in order to evaluate teaching methods. Adjust your approach as needed.

UNIT REFERENCES

- Curriculum and Instructional Materials Center, *Medication Administration Technician*, Oklahoma Department of Vocational and Technical Education, Stillwater, Oklahoma, 1989.
- Curriculum and Instructional Materials Center, *Nursing Principles and Skills*, Oklahoma Department of Vocational and Technical Education, Stillwater, Oklahoma, 1992.

SUGGESTED RESOURCES

Audiovisual Materials

- *Universal Precautions for Health-Care Workers*. Color, 18:45 minutes, VHS.

  Available to Oklahoma teachers on a free-loan basis. Oklahoma teachers may order these films from the Oklahoma Department of Vocational and Technical Education, Resource Center, ATTN: Instructional Media Specialist, 1500 West Seventh Avenue, Stillwater, Oklahoma 74074, or call 800-522-5810. The videotape is also available from:

  Syntex Public Affairs Department
  A1-195
  3401 Hillview Avenue
  Palo Alto, CA 94304
  (415) 855-5048

INFORMATION SHEET	CONTROL INFECTION 1
OBJECTIVE 1	**Match terms associated with infection control to their correct definition.**

- **Blood spills** — Blood from the mouth, the nose, or a wound
- **Body fluids** — Include blood spills, menstrual blood, mucous, saliva, urine, feces, vomit, and diarrhea
- **Communicable** — Capable of being passed from one person to another
- **Contaminate** — To introduce disease-causing material
- **Hygiene** — Practices or conditions that promote good health
- **Infection** — A disease state caused by pathogenic organisms
- **Microorganism (microbe)** — A very small living thing that can be seen only through a microscope

  EXAMPLE: Germs, bacteria, viruses, protozoa
- **Microscopic** — Able to be seen only with a microscope
- **Parasite** — An organism that lives inside or upon another organism (the "host")
- **Pathogenic** — Capable of causing disease

OBJECTIVE 2

Distinguish among types of microbes that can cause an infection.

- **Bacteria** — A microscopic plant; some can help the body by producing enzymes that turn food into energy, while others can hurt the body by producing a toxin (poison)
- **Fungi** — A type of microbe that includes molds and yeasts

  EXAMPLE: Ringworm, athletes foot

- **Protozoa** — Microscopic animals that can cause infection

  EXAMPLE: Malaria, amebic dysentery

- **Rickettsiae** — A microbe that occupies a place between viruses and bacteria, and which are usually transmitted by lice, fleas, ticks and mites

  EXAMPLE: Rickettsial infections include Rocky Mountain Spotted Fever and typhus.

- **Virus** — A microbe that can only survive in a living cell

  EXAMPLE: Measles, smallpox, influenza

OBJECTIVE 3 **Describe the links in the "chain of infection."**

The steps in the spread of infection are often called the "chain of infection." Infections can be prevented if any of the "links" in the chain are broken.

- A microorganism (microbe)

  A specific microbe must be present to cause an infection. This microbe could be a virus, bacteria, fungus, protozoa, rickettsiae or other microorganism.

- A reservoir

  The microbe must have a place to grow and multiply. This "place" is a *reservoir.* A reservoir can be a human being, an animal, food, water, an object, or other "place." For example, most microbes are parasites. The host is a reservoir for the parasite.

- Means of exit (from the reservoir)

  The microbe must have some way of leaving its reservoir. The *exit* is the way in which the microbe escapes from its reservoir. For example, the exit from a human being can be the person's mouth or nose, or a surgical wound or an accidental cut.

- Method of transmission (to the victim)

  After leaving its reservoir, the microbe must be able to transfer to its potential victim (such as from one person to another). This transfer can result (1) from direct or indirect contact between two living organisms, (2) through the air in dust or droplets, or (3) through a contaminated "vehicle" such as food, water, blood, or drugs.

- Means of entry (into the victim's body)

  The microbe must have some way of getting into the new victim's body. The means of *entry* is the path that the microbe takes to enter the body. Any opening that acts as a means of exit can also act as a means of entry.

- A susceptible victim (new host)

  Microbes are always present. A person may be able to tolerate many disease-causing microbes. However, when the person's natural body defenses are reduced for some reason, the person can become susceptible to infection. For example, a poorly-balanced diet, poor personal hygiene, illness, physical or emotional stress, or even some medical treatments will help to lower a person's natural defenses and increase the chances of infection. The new host becomes a new *reservoir.*

OBJECTIVE 4 **List common ways that microbes can spread infection.**

BY DIRECT CONTACT

- Touching an infected person
- Contact with the body fluids of an infected person
- Contact with the urine or feces of an infected person

BY INDIRECT CONTACT (CONTACT WITH A CONTAMINATED "VEHICLE")

- Dishes, glassware, or silverware
- Tissues
- Dressings

- Clothing
- Bed linen
- Instruments, such as needles
- Food or water
- Blood

THROUGH THE AIR — Disease-causing microbes spreading in the air through dust particles or droplets (such as sneezing)

OBJECTIVE 5

Select from a list guidelines for preventing infection through good personal hygiene.

- Wash your hands *before and after* any contact with each resident.

  NOTE: Your hands are constantly in contact with microbes. Unwashed hands are also the most common means of transmitting infection from one person to another, directly or indirectly. Frequent and effective handwashing can help break the chain of infection.

- Keep your fingernails short and smooth.
- Wear clean clothes every day.

  NOTE: Fabrics absorb odors and collect germs.

- Bathe every day, including washing your hair.

  NOTE: This will remove any contamination that you may have received during the day.

- Report to your supervisor if you feel sick or notice any signs or symptoms of a communicable disease.

OBJECTIVE 6 **Select from a list guidelines for preventing infection through good housekeeping.**

- Keep areas around medications clean at all times.
- Keep medication containers clean.
- Avoid touching medications.

  EXAMPLE: When obtaining solid medication from stock containers, first pour the required number into the container's cap, then transfer the medication to a medicine cup.

- Throw away any medication that has touched the floor.
- Use disposable items to control the chances of contamination.

  EXAMPLE: Paper cups, paper towels and tissues

- Clean up spills immediately.
- Sweep floors and vacuum carpets often.

  NOTE: This will help remove dirt, which can support germs.

- Empty trash cans frequently.

  NOTE: Trash can support the growth of germs that can cause infection.

- Store clean linen away from soiled linen.
- Store soiled linen in the appropriate containers.

OBJECTIVE 7 **State special precautions relating to blood spills/body fluids.**

Medical histories and examinations cannot reliably identify all residents who may have the AIDS virus or other diseases and infections. Therefore, the MAT should follow these precautions with *every resident.*

PERSONAL PROTECTIVE EQUIPMENT

- Wear gloves when touching blood and body fluids, mucous membranes, or broken skin of all residents.
- Wear gloves when handling items or touching surfaces soiled with blood or body fluids.
- Wear gloves during any procedures that involve access to blood.
- Change gloves after contact with each resident.
- Wear masks, protective eyewear or face shields, and gowns or aprons as needed to prevent exposure to the mucous membranes of the resident's mouth, nose, and eyes during procedures that may cause spattering of blood or other body fluids.

PERSONAL HYGIENE

- Be especially careful to prevent injuries from handling needles, scalpels and other instruments during procedures, clean-up, and disposal.
- Wash your hands immediately and thoroughly after removing gloves.
- Wash your hands and other skin surfaces immediately and thoroughly if they become contaminated with blood or other body fluids.

GOOD HOUSEKEEPING

- Place disposable needles, syringes, scalpel blades and other sharp items in a puncture-resistant container for disposal.

CAUTION

Needles can be the cause of personal injury. Do not recap, bend, or break needles. Do not remove needles from disposable syringes or otherwise handle these needles by hand.

- Place puncture-resistant containers as close as possible to the area where they will be needed.

- Place large-bore reusable needles in a puncture-resistant container for transport to a reprocessing area.

- Store mouthpieces, resuscitation bags, and other ventilation devices in areas where the need for resuscitation is predictable.

JOB SHEET 1	CONTROL INFECTION 1

OBJECTIVE 8

Properly wash your hands.

INTRODUCTION

Unwashed hands are the most common means of transmitting infection from one person to another, directly or indirectly. Your hands are in almost constant contact with microorganisms. For example, think about all of the objects and surfaces that you have touched since waking up this morning. Did you wash your hands after touching each item? How many of these objects had been touched by someone else and would be touched after your contact with them? Each object can be a possible reservoir or method of transmission for microbes that can cause infection. Frequent and effective handwashing can help break the chain of infection.

EQUIPMENT AND MATERIALS

- Soap

  NOTE: Liquid soap is preferred, since microbes from your hands can cling to bar soap. However, bar soap can be effective if used with care.

- Running water
- Paper towels

PROCEDURE

Functional Reading Skills
- Follow written instructions

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

1. Remove watches, rings and other jewelry from your hands.
2. Turn the water on with a paper towel and adjust the water to a comfortable, warm temperature.

   CAUTION

   Avoid touching the sink or faucet. They should be considered "contaminated." You should avoid touching the sink or faucet by turning the faucet on and off using a dry paper towel.
3. Stand in front of the sink, without touching the sink.
4. Wet your hands completely, without splashing.
5. Apply plenty of soap. If you use bar soap, rinse the bar before putting it back in the soap dish.
6. Keeping your hands lower than your elbows, firmly scrub your hands and wrists:

a. Scrub all of the surfaces of your hands, including the backs of your hands and between your fingers.

b. Scrub your wrists at least two inches above the wrist (or higher, depending on the soil).

c. Clean under and around the fingernails on each hand by pressing the fingertips of each hand on the open palm of the opposite hand.

7. Keeping your hands lower than your elbows, rinse your hands thoroughly under running water.

CAUTION

Never rinse your hands in a sink of standing water. Standing water can act as a reservoir for the microorganisms that you are trying to wash away. Always rinse your hands under running water.

8. Dry your hands completely with a clean paper towel.

9. Turn the water off with a dry paper towel.

10. Throw away all used paper towels.

PRACTICAL TEST 1	CONTROL INFECTION 1

JOB SHEET 1

Properly wash your hands.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Obtained proper equipment and materials.	_____	_____
2. Removed all jewelry from hands before washing.	_____	_____
3. Turned water on properly.	_____	_____
4. Applied plenty of soap.	_____	_____
5. Kept hands lower than elbows while washing.	_____	_____
6. Scrubbed all surfaces of hands.	_____	_____
7. Scrubbed wrists.	_____	_____
8. Cleaned under and around fingernails.	_____	_____
9. Rinsed hands under running water.	_____	_____
10. Dried hands and turned water off properly.	_____	_____

EVALUATOR'S COMMENTS

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
All surfaces of both hands are clean.	4	3	2	1
Wrists are clean to at least 2 inches above the wrists.	4	3	2	1
Fingernails are clean.	4	3	2	1
Bar soap, if used, has been rinsed off immediately after use.	4	3	2	1
Water faucet is turned off.	4	3	2	1
Hands have not become contaminated by touching sink or faucet before, during, or after procedure.	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 —	Skilled — Can perform job with no additional training.
3 —	Moderately skilled — Has performed job during training program; limited additional training may be required.
2 —	Limited skill — Has performed job during training program; additional training is required to develop skill.
1 —	Unskilled — Is familiar with process, but is unable to perform job.

CONTROL INFECTION

NAME _____ SCORE _____

OBJECTIVE 1

Match terms associated with infection control to their correct definition. Write the correct letter in each blank.

_____1. An organism that lives inside or upon another organism (the "host")

_____2. A disease state caused by pathogenic organisms

_____3. To introduce disease-causing material

_____4. A very small living thing that can be seen only through a microscope

_____5. Capable of being passed from one person to another

_____6. Include blood spills, menstrual blood, mucous, saliva, urine, feces, vomit, and diarrhea

_____7. Able to be seen only with a microscope

_____8. Capable of causing disease

_____9. Blood from the mouth, the nose, or a wound

_____10. Practices or conditions that promote good health

a. Blood spills
b. Body fluids
c. Communicable
d. Contaminate
e. Hygiene
f. Infection
g. Microorganism (microbe)
h. Microscopic
i. Parasite
j. Pathogenic

OBJECTIVE 2

Distinguish among types of microbes that can cause an infection. Write the name of the type of microbe in each blank.

1. _____ — A microscopic plant; some can help the body by producing enzymes that turn food into energy, while others can hurt the body by producing a toxin (poison)

2. _____ — A type of microbe that includes molds and yeasts

3. _____ — Microscopic animals that can cause infection

4. _____ — A microbe that occupies a place between viruses and bacteria, and which are usually transmitted by lice, fleas, ticks and mites

5. _____ — A microbe that can only survive in a living cell

OBJECTIVE 3

Describe the links in the "chain of infection." Briefly describe (1-2 sentences) each of the links.

- A microorganism (microbe)

_____

_____

_____

_____

- A reservoir

_____

_____

_____

_____

- Means of exit (from the reservoir)

_____

_____

_____

_____

- Method of transmission (to the victim)

_____

_____

_____

_____

- Means of entry (into the victim's body)

_____

_____

_____

_____

- A susceptible victim (new host)

_____

_____

_____

_____

OBJECTIVE 4

List common ways that microbes can spread infection. Give eight (8) examples of ways that microbes can spread infection by direct contact, indirect contact, or through the air.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

OBJECTIVE 5

Select from a list guidelines for preventing infection through good personal hygiene. Write an "X" in the blank before each correct guideline.

_____1. Wash your hands *only after* any contact with each resident.

_____2. Keep your fingernails short and smooth.

_____3. Wear clean clothes every day.

_____4. Bathe every day and wash your hair every other day.

_____5. Always use bar soap for washing hands.

_____6. Report to your supervisor if you feel sick or notice any signs or symptoms of a communicable disease.

OBJECTIVE 6

Select from a list guidelines for preventing infection through good housekeeping.

_____1. Keep areas around medications clean at all times.

_____2. Avoid touching medications.

_____3. Throw away any medication that has touched the floor.

_____4. Use disposable items to control the chances of contamination.

_____5. Clean up spills before the end of your shift.

_____6. Sweep floors and vacuum carpets often.

_____7. Empty trash cans frequently.

_____8. Store clean linen on top of soiled linen.

OBJECTIVE 7 **State special precautions relating to blood spills/body fluids.**

PERSONAL PROTECTIVE EQUIPMENT

1. _____

_____

2. _____

_____

3. _____

_____

PERSONAL HYGIENE

1. _____

_____

2. _____

_____

GOOD HOUSEKEEPING

1. _____

_____

2. _____

_____

NOTICE The following objective is not a part of the Written Test.

OBJECTIVE 8 **Properly wash your hands.** RATING _____

OBJECTIVE 1

1. i
2. f
3. d
4. g
5. c
6. b
7. h
8. j
9. a
10. e

OBJECTIVE 2

1. Bacteria
2. Fungi
3. Protozoa
4. Rickettsiae
5. Virus

OBJECTIVE 3

- A microorganism (microbe)

  A specific microbe must be present to cause an infection. This microbe could be a virus, bacteria, fungus, protozoa, rickettsiae or other microorganism.

- A reservoir

  The microbe must have a place to grow and multiply. This "place" is a *reservoir*. A reservoir can be a human being, an animal, food, water, an object, or other "place." For example, most microbes are parasites. The host is a reservoir for the parasite.

- Means of exit (from the reservoir)

  The microbe must have some way of leaving its reservoir. The *exit* is the way in which the microbe escapes from its reservoir. For example, the exit from a human being can be the person's mouth or nose, or a surgical wound or an accidental cut.

- Method of transmission (to the victim)

  After leaving its reservoir, the microbe must be able to transfer to its potential victim (such as from one person to another). This transfer can result (1) from direct or indirect contact between two living organisms, (2) through the air in dust or

droplets, or (3) through a contaminated "vehicle" such as food, water, blood, or drugs.

- Means of entry (into the victim's body)

  The microbe must have some way of getting into the new victim's body. The means of *entry* is the path that the microbe takes to enter the body. Any opening that acts as a means of exit can also act as a means of entry.

- A susceptible victim (new host)

  Microbes are always present. A person may be able to tolerate many disease-causing microbes. However, when the person's natural body defenses are reduced for some reason, the person can become susceptible to infection. For example, a poorly-balanced diet, poor personal hygiene, illness, physical or emotional stress, or even some medical treatments will help to lower a person's natural defenses and increase the chances of infection. The new host becomes a new *reservoir*.

OBJECTIVE 4

Any eight (8) of the following:

- Touching an infected person
- Contact with the body fluids of an infected person
- Contact with the urine or feces of an infected person
- Dishes, glassware, or silverware
- Tissues
- Dressings
- Clothing
- Bed linen
- Instruments, such as needles
- Food or water
- Blood
- Disease-causing microbes spreading in the air through dust particles or droplets (such as sneezing)

OBJECTIVE 5

2, 3, 6

OBJECTIVE 6

1, 2, 3, 4, 6, 7

OBJECTIVE 7

PERSONAL PROTECTIVE EQUIPMENT — Any three (3) of the following:

- Wear gloves when touching blood and body fluids, mucous membranes, or broken skin of all residents.
- Wear gloves when handling items or touching surfaces soiled with blood or body fluids.
- Wear gloves during any procedures that involve access to blood.
- Change gloves after contact with each resident.
- Wear masks, protective eyewear or face shields, and gowns or aprons as needed to prevent exposure to the mucous membranes of the resident's mouth, nose, and eyes during procedures that may cause spattering of blood or other body fluids.

PERSONAL HYGIENE — Any two (2) of the following:

- Be especially careful to prevent injuries from handling needles, scalpels and other instruments during procedures, clean-up, and disposal.
- Wash your hands immediately and thoroughly after removing gloves.
- Wash your hands and other skin surfaces immediately and thoroughly if they become contaminated with blood or other body fluids.

GOOD HOUSEKEEPING — Any two (2) of the following:

- Place disposable needles, syringes, scalpel blades and other sharp items in a puncture-resistant container for disposal.
- Place puncture-resistant containers as close as possible to the area where they will be needed.
- Place large-bore reusable needles in a puncture-resistant container for transport to a reprocessing area.
- Store mouthpieces, resuscitation bags, and other ventilation devices in areas where the need for resuscitation is predictable.

OBJECTIVE SHEET	**ADMINISTER MEDICATION** 2

INTRODUCTION

Properly administering medication is a critical skill for every medication administration technician (MAT). Some persons require medications for specific illnesses; others require medications simply to stay alive. As a MAT, you are responsible for administering medications safely, accurately and timely.

UNIT OBJECTIVE

After completing this unit, you should be able to build upon your current skills relating to the administration of medication.

PREREQUISITES

Before studying this unit, you should have successfully completed the *Medication Administration Technician* training program.

SPECIFIC OBJECTIVES

After completing this unit, you should be able to

1. Verify rights of medication administration.
2. Explain the importance of factors in a resident's personal medical history (to be considered before administering medication).
3. State the checkpoints for verifying a medication during preparation.
4. Identify forms of medications.
5. Match common medications to their predominant side effects.
6. Identify requirements for properly storing and handling medications.
7. State requirements for storing, using and documenting a controlled drug.
8. Identify the documentation necessary when administering medication.
9. Select from a list guidelines for preparing client medication for transport to a workshop.
10. Administer oral medication in liquid form. (Job Sheet 1)
11. Administer oral medication in pill form. (Job Sheet 2)

12. Administer eye medication. (Job Sheet 3)

13. Administer ear medication. (Job Sheet 4)

14. Administer nasal medication. (Job Sheet 5)

PREPARATION

- Order additional materials to supplement this unit:
  - — Posters and charts on rules of administering medications
  - — Drug reference books such as the *Physician's Desk Reference* and others
- Review the unit and plan your presentation:
  - — Estimate the amount of material that can be covered in each class session.
  - — Identify objectives that you can supplement with other resources.
  - — Invite guest speakers in advance.
- Design transparencies and handouts to reinforce the objectives in each unit, to provide additional information, or to facilitate in-class activities.
- Arrange for any needed demonstrations and accompanying media.
- Arrange for any needed equipment and blank forms for student practice.

DELIVERY

Objective 1

- Have students recite the rights of medication administration.
- Ask students how the rights are verified in their facility.
- Discuss methods of verifying each of the rights.
- Create scenarios in which a resident denies his/her identity. Have pairs of students role-play each scenario, then discuss each scenario as a group. Be sure to point out correct and incorrect responses from each role-play.

Objective 2

- Describe possible situations that show the importance of each factor to medication administration.

Objective 3

- Demonstrate verifying a medication at each checkpoint.
- Discuss the importance of each checkpoint.
- Ask students to demonstrate verifying a medication using the checkpoints. Point out correct procedures and areas for improvement (or ask other students to identify these).

Objective 4

- Provide samples of each form, if possible.
- Explain the purposes of each form.
- Demonstrate reading a medicine glass. Ask students to demonstrate.
- Demonstrate crushing medication. Describe situations when a medication might require crushing. Give examples of medications that should not be crushed. Ask students to demonstrate.

Objective 5

- Demonstrate how to use drug reference books such as the *Physicians' Desk Reference* and others.
- Explain the color code used in the *Physicians' Desk Reference*. Demonstrate the usefulness of this resource. The color code includes the following:
  - — Manufacturers' Index (white pages)
  - — Product Name Index (pink pages)
  - — Product Category Index (blue pages)
  - — Generic and Chemical Name Index (yellow pages)

— Product Information Section (white pages)

— Diagnostic Product Information (green pages)

- Discuss Supplement 1.

Objectives 6 and 7

- Discuss the importance of each requirement.

Objectives 8 and 9

- Show sample forms used to document required information, or design sample forms as a group.
- Review the routes of administration.
- Give examples of special orders.
- Discuss Supplement 2.

APPLICATION

Objectives 10 through 14

- Demonstrate the procedures for administering each type and form of medication on the Job Sheets.
- For each Job Sheet, describe possible situations that could complicate the procedure. Ask students how they would respond.
- Schedule students for practicing Job Sheet procedures and for taking Practical Tests.

EVALUATION

Practical Test

- Explain to students that they will be asked to demonstrate procedures on the Job Sheets to complete the Practical Tests.
- Describe the rating scale used on the Practical Test.
- Reteach and retest as necessary.
- Counsel students individually on the results of their Practical Tests.

Written Test

- Give the Written Test soon after presenting the unit.
- Remind students throughout your presentation that the questions and required performance on each Written Test match the Specific Objectives stated at the beginning of the unit and the objectives discussed in the unit.

UNIT REFERENCES

- Curriculum and Instructional Materials Center, *Medication Administration Technician*, Oklahoma Department of Vocational and Technical Education, Stillwater, Oklahoma, 1989.
- Curriculum and Instructional Materials Center, *Pharmacology*, Oklahoma Department of Vocational and Technical Education, Stillwater, Oklahoma, 1990.
- East Central University, Division of Adult and Continuing Education, *MAT Update*, East Central University, Ada, Oklahoma.

INFORMATION SHEET	ADMINISTER MEDICATION 2
OBJECTIVE 1	**Verify rights of medication administration.**

BEFORE ADMINISTERING MEDICATIONS

- Right resident
- Right time and date
- Right medication
- Right dosage
- Right dosage form
- Right route of administration

AFTER ADMINISTERING MEDICATIONS

- Right charting

OBJECTIVE 2

Explain the importance of factors in a resident's personal medical history (to be considered before administering medication).

- **Allergies** — All residents should be asked about drug allergies and caution should be used if this is the resident's first time for this medication.
- **Age** — Age affects the rate in which the body metabolizes the medication. Older adults metabolize medication slowly; infants and children may metabolize medication very rapidly.
- **Body Build** — Body weight, as well as the percentage of body fat and muscle tissue affects the metabolizing of medication.
- **Diagnosis** — Diseases may change the way medication works.
- **Drug tolerance** — Tolerance can be assessed only after the medication has been given. You should be aware of the resident's reaction to the medication if it was given previously. Drug tolerance changes during the aging process.

- **Emotional state** — The emotional state of the resident may affect how that person perceives the medication and how effective the medication is for treating the illness.

- **Indication** — You should know the reasons for a particular resident receiving a medication.

- **Physical state** — A resident's physical ability to tolerate a drug or the route being used. A resident who is vomiting cannot take medication orally, so a change in route must be made.

- **Present symptoms** — Some symptoms may indicate drug toxicity or other contraindications to giving that medication or may indicate the need for more effective medication.

OBJECTIVE 3

State the checkpoints for verifying a medication during preparation.

1. When you obtain the medication from the storage area.
2. While you are pouring the medication.
3. When you return the medication to the proper storage area.

NOTE: Following these checkpoints decreases the chance of an incorrect medication being used.

OBJECTIVE 4

Identify forms of medications.

ORAL

- **Tablet** — A disk of compressed dry drug that varies in shape; may be scored for division

- **Capsule** — Drug is placed in gelatin type of container

- **Enteric (Coated tablet)** — Tablet with special coating that does not break down until it reaches the small intestine

- **Time-release (Sustained-release) capsule** — Coated capsule containing drug particles that dissolve in a specified length of time

- **Lozenge** — Flavored tablet for local effect on the throat

  NOTE: Lozenges should not be swallowed.

- **Suspension** — Liquid medication that requires shaking because settling of drug particles occurs

- **Emulsion** — Liquid medication that contains oils and fats in water

- **Elixir, Fluid, Extract** — Liquid medication with an alcohol base

- **Syrup** — Liquid medication that is sweetened and flavored

- **Solution** — Liquid medication in which a drug is evenly dissolved and appears clear

RECTAL

- **Suppository** — Drug suspended in a substance that melts at body temperature

- **Enema solution** — Drug suspended in a solution to be given as an enema

TOPICAL

- **Transdermal patch** — Medication applied to the skin and absorbed over a long period of time

- **Ointment** — Semi-solid preparation of a drug for external application

- **Liniment** — External application that acts as a counterirritant

- **Lotion** — Liquid preparation of a drug for external application

MUCOSAL

- **Eye, Ear, and Nose Drops** — Liquid medication that is made for administration into a specified area

- **Eye ointment** — Sterile semi-solid preparation for ophthalmic use only

- **Vaginal cream** — Medicated cream to be applied to the vagina with use of a special applicator

- **Buccal tablet** — Tablet made to be placed between the cheek and the gum

- **Sublingual tablet** — Tablet made to be placed under the tongue

  NOTE: One of the most common medications found in sublingual form is nitroglycerine tablets. These are used for angina or chest pain. Sublingual medications work very rapidly and should not be confused with oral medications, which work much slower. Sublingual tablets are placed under the tongue, where rapid absorption takes place.

INHALANT

- **Spray (or Mist)** — Liquid drug form to be inhaled as fine droplets by use of spray bottles or nebulizer

- **Gas** — Anesthetics to be inhaled for general anesthesia

- **Powder** — Powder form of drug administered through an inhaler

OBJECTIVE 5 **Match common medications to their predominant side-effects.**

NOTE: The information in this objective does not replace standard reference texts, such as the *Physician's Desk Reference* (PDR) or others.

VASCULAR AND CARDIAC AGENTS
(Digitalis and Glycosides)

- Common reaction is due to toxicity (too much of the drug in the bloodstream)

- Flu-like symptoms may appear

- Visual disturbances and headaches

What the MAT Should Do

These are the agents of choice for congestive heart failure, but are used sometimes for arrhythmias (an irregular or loss of rhythm of the heartbeat). Congestive heart failure is a syndrome where the heart fails to maintain an adequate output, resulting in a lower blood flow to the tissues. The medication helps the heart to become a more efficient pump.

- Take an appical pulse rate before administering the medication. If the resident's pulse is less than 60 beats per minute, do not give the medication—report the condition to your supervisor.
- If flu-like symptoms appear, call a physician immediately.

DIURETICS

EXAMPLE: Diuril, Dyazide, Hydrochlorothiazide (HCL), Hydrodiuril, Lasix

- Often decrease the amount of potassium in the resident
- Can lead to muscle aches and confusion (from a decrease in potassium)

What the MAT Should Do

These drugs are used to increase the amount of urine and thereby reduce the amount of fluid in the blood vessels. These drugs are commonly given with the cardiac agents listed previously to aid in congestive heart failure and to lower high blood pressure.

- Encourage the resident to drink orange juice or eat foods high in potassium, such as bananas. (Also, a diuretic is often prescribed with a potassium supplement such as Kaon-Cl, K-Dur, K-Lor or K-Lyte.)
- Report any reduction in potassium in any resident to a physician immediately. A reduction in potassium in the body can be potentially dangerous.

NITRATES

EXAMPLE: Isordil, Nitrobid, Nitroglycerin, TransDerm-Nitro

- Headaches, faintness and dizziness (most common)
- Nausea and vomiting may occur
- Lowering of blood pressure when the resident gets up

What the MAT Should Do

Nitrates are used to relax smooth muscles, dilate small blood vessels and may increase the blood supply to the heart. The most commonly used nitrate is sublingually administered nitroglycerine.

- Advise the resident to ask for help before getting up.
- Keep the medication in its original glass container and throw it away three months after it is opened. Nitrates can lose effectiveness quickly.

ANTIHYPERTENSIVES

EXAMPLE: ACE inhibitors (Capoten, Vasotec), Beta-adrenergic blockers (Inderal, Tenormin, Lapressor), calcium-channel blockers (Cardizem, Isoptin), central alpha-adrenergic (Adlomet, Catapres, Wytensin), peripheral vasodilators (Hytrin, Minipres)

- Each different class works in a different way.
- Side-effects are dependent on how the particular medication works.

What the MAT Should Do

Antihypertensive drugs are used to prevent or to control high blood pressure. To find the particular side effects of a specific drug, look up that medication in an appropriate reference book.

NEUROSES AND PSYCHOSES

EXAMPLE: Tricyclic antidepressants (Elavil, Sinequan, Tofanil), monoamine oxidase inhibitors (Desyril, Nardil), antipsychotic agents (Compazine, Haldol, Mellaril, Thorazine, Trilafon)

Tricyclic antidepressants

- Drowsiness (most common)
- Dry mouth
- Blurred vision
- Dizziness upon standing too quickly
- Irregular heartbeats

Monoamine oxidase inhibitors

- Hypertensive crises (rapid rise in blood pressure which can cause immediate health problems)
- Other potentially dangerous side effects

What the MAT Should Do

- Monitor residents closely, including their diets. Residents on these medications should not eat foods high in tyramine, such as aged cheese, wines, beers, pickled herring, chicken liver or yeast extract.
- Refer immediately to a reference book for the complete facts on side effects.

Antipsychotic agents

- Sedative effect—causes drowsiness

- Extra-pyramidal symptoms:

    1. Pseudoparkinsonism — Resembles true Parkinsonism such as tremor, mask-like facial expressions, drooling and some restlessness

    2. Akinesia — Complete or partial loss of a muscle movement (be sure to be alert if your resident complains of fatigue and weakness of the arms and legs).

    3. Akathisia — Motor restlessness; your resident may be extremely restless, continually moving hands, mouth and body.

    4. Dyskinesia — Less common disturbance that takes many forms such as torsion or twisting spasms, drooping of the head, protrusion of the tongue and other facial disturbances. The resident may complain of stiff neck and an inability to swallow. (This can be very frightening, so be sure to reassure your resident and inform his/her physician as soon as possible.)

ANTICONVULSANTS

EXAMPLE: Depakene, Dilantin, Mysoline, Phenobarbital, Tegretol

- Phenobarbital can cause a slowing of respirations, as well as dizziness and drowsiness.

- Dilantin can cause a condition of the gums called gingival hyperplasia (requiring gum massage and good oral hygiene to prevent tooth loss), slurred speech, dizziness, insomnia and depression.

What the MAT Should Do

These medications are used to control seizure activity. The most common form of attack begins with loss of consciousness and motor control and jerking of all extremities. Any recurrent seizure pattern may be termed "epilepsy." Anticonvulsant medications should be closely monitored in order to produce a drug level high enough for the resident to have as few side effects as possible to maintain a seizure-free status. It is extremely important for the resident to take these medications as scheduled. If any dose is missed, the physician may need to be called to determine if another dose could be given safely.

- Observe residents taking phenobarbital—be sure they do not injure themselves due to dizziness or confusion.
- Refer to appropriate reference books for the complete facts on side effects.

ANTIARTHRITIC AND ANTIGOUT AGENTS

EXAMPLE: Antiarthritic agents (Clinoril, Feldene, Indocine, Meclomen, Motrin, Nalfon, Naprosyn, Rufen), antigout agents (Zyloprim)

- Most common side-effects are related to the gastro-intestinal tract such as nausea with or without vomiting, diarrhea, constipation and abdominal cramps and pain.

What the MAT Should Do

All the above medications are used in the treatment of arthritis or joint pain and for gout. Each of the individual medications above should be researched in a drug reference book for further information.

NEW MEDICATIONS

EXAMPLE: Prozac (to treat depression), Colestid and Questran (to lower the lipid content of the blood), Mevacor (to lower the cholesterol in the bloodstream), Ansaid (for rheumatoid arthritis and osteoarthritis)

Prozac

- Loss of appetite and significant weight loss in some people
- Headache, nervousness and insomnia may occur.

NOTE: Consult an appropriate reference book for a full list of side effects.

What the MAT Should Do

Carefully monitor the client's weight.

Colestid and Questran

- Constipation, sometimes accompanied by fecal impaction and aggravation of hemorrhoids
- Abdominal discomfort (pain and distention), belching and flatulence (gas) is frequently seen.

What the MAT Should Do

- These medications are in granular form—always mix them with at least three fluid ounces of water or other liquid such as orange juice.
- Rinse the glass with a small amount of additional liquid, to make sure that all of the medication is taken. (This medication will not dissolve.)
- Mix these medications with highly-fluid soup or moist, pulpy fruit such as applesauce or crushed pineapple, or with milk in hot or cold breakfast cereal, if desired.
- Never give these medications *dry*.

Mevacor

- Abdominal pain/cramps, gas and diarrhea are frequently seen.

- Some side effects will ease, the longer the client takes the medication.

Ansaid

- Diarrhea, abdominal pain, nausea and vomiting may be seen.
- Headaches with dizziness and blurred vision may be seen.

NOTE: Consult an appropriate reference book for a full list of side effects.

OBJECTIVE 6 **Identify requirements for properly storing and handling medications.**

The MAT is responsible for the handling and storage of various medications, both over the counter and prescription medication. Most medications can be safely stored in a cool, dry area. However, certain medications require special handling.

- Refrigerate insulin, liquid antibiotics and suppositories.
- Be sure that any medication in a suspension form is "shaken well."
- Take note of the expiration date on all medications.
- Keep all medications in their original containers showing the resident's first and last name.
- Lock all medications and double-lock narcotics.

  NOTE: Document medications taken by a resident.
- Note any special pharmacy labels on medication bottles.
- DO NOT STORE MEDICATIONS WITH NON-DRUG ITEMS.
- Keep medications of individual residents separate.
- Store medications applied externally separately from medications taken internally.

- Do not administer to any resident the prescribed medication or over-the-counter medication of another resident.
- Do not allow any resident to possess the prescribed or over-the-counter medications of another resident.
- Never keep a bulk supply of medications.

  NOTE: Each resident must have his/her own medications; these must be ordered and approved by his/her doctor.

OBJECTIVE 7

State requirements for storing, using and documenting a controlled drug.

Federal law requires very accurate records covering the storage, use and documentation of a controlled substance.

- Double-lock all narcotics.

  NOTE: This means that two keys are needed to obtain the medication from the storage area.
- Take a complete count of all narcotics at the beginning and end of each shift.
- Record the following information each time a client is administered a dose of a controlled drug:
  - Client's name
  - Exact date and time
  - Name of the medication
  - Amount given and route given
  - Name of doctor(s) ordering the medication
  - Name of person administering the medication
  - Amount (number) of the medication remaining in the container

OBJECTIVE 8

Identify the documentation necessary when administering medication.

NOTE: To correctly document the administration of medication, you must obtain certain information from the medication container or from the doctor's written orders. Regardless of what your forms look like, the following information must be documented on those forms.

- Resident's first and last name
- Name of the medication
- Dosage or amount of the medication to be administered
- Route of administration
- Required daily frequency of administration
- Any special orders

  EXAMPLE: Administer the medication before meals, administer the medication with food

OBJECTIVE 9

Select from a list guidelines for preparing client medication for transport to a workshop.

- Place each medication in a separate, labeled medication bottle.
- Make sure that the label states the name of the medication, its strength, the route the medication is to be administered, the number that must be taken, and the frequency the medication is to be taken.
- Place the medication bottle(s) in a container such as a zip-lock bag or a box that has been labeled with the client's first and last name.

BRAND NAMES AND GENERIC NAMES

MEDICATION	BRAND NAME	GENERIC NAME
VASCULAR AND CARDIAC AGENTS	Lanoxin	Digoxin
	Crystodigin	Digitoxin
DIURETICS	Diuril	Chlorothiazide
	HydroDiuril	Hydrochlorothiazide (HCL)
	Lasix	Furosemide
	Dyazide	Triamterene and hydrochlorothiazide
	Maxzide	Triamterene and hydrochlorothiazide
NITRATES	Isordil	Isosorbide dinitrate
	Nitro-Bid	Nitroglycerine Caps
	Nitro-Dur	Nitroglycerine
	NitroStat	Nitroglycerine
	Transdermal-Nitro	Nitroglycerine patch
ANTIHYPERTENSIVES	Calan	Verapamil
	Inderal	Propranolol HCL
	Aldomet	Methyldopa Tabs
	Catapres	Clonidine HCL
	Minipress	Prazosin HCL Caps
NEUROSES AND PSYCHOSES	Elavil	Amitriptyline
	Trival	Perphenazine with Amitriptyline
	Sinequan	Doxepin
	Tofranil	Imipramine HCL Tabs
	Compazine	Prochlorperazine Meleate
	Haldol	Haloperidol
	Mellaril	Thioridazine
	Thorazine	Chlorpromazine HCL
	Librium	Chloriazepoxide HCL Caps
	Valium	Diazepam
ANTICONVULSANTS	Dilantin	Phenytoin Sodium
	Depakene	Valproic Acid
	Mysoline	Primidone
	Tegretol	Carbamazephine F.C. Tabs

MEDICATION	BRAND NAME	GENERIC NAME
ANTIBIOTICS	Amoxil	Amoxicillin Caps
	E.E.S.	Erthromycin Ethylsuccinate Tabs
	E-Mycin	Erthromycin Delayed Released
	ERYC-250	Erthromycin
	Keflex	Cephalexin
	Pen-Vee-K	Penicillin V Tabs
ANTIARTHRITICS	Clinoril	Sulindac
	Motrin	Ibuprofen Tabs
	Meclomen	Meclofenamate Sodium
	Nalfon	Fenoprofen
ANTIGOUT	Zyloprim	Allopurinol
PAIN RELIEF	Darvon 65	Propoxphene HCL
	Darvocet N	Propoxphene Napsylate with APAP
	Empirin with Codeine	Aspirin with Codeine
	Fiorinol	Mygranol Butalbital with aspirin and caffeine
	Tylenol with Codeine	Acetaminophen with Codeine

GUIDELINES FOR ADMINISTERING VARIOUS MEDICATIONS

ORAL MEDICATION

- Avoid touching the medication, if possible.
- When administering liquid medication, place the medicine cup at eye level with the label turned away.

  NOTE: This will prevent the liquid from dripping down the label and making the label hard to read.
- Determine *whether* to crush a medication.

  NOTE: Clients are often unable to take the solid form of oral medications.
- Determine whether a particular medication *can* be crushed.

  NOTE: Enteric-coated medication and timed-release medication should not be crushed. Crushing such medications would probably crush the coating that makes the medication slow to dissolve. Check with a pharmacist.
- Determine what substances a crushed medication can be combined with for safe administration.

  EXAMPLE: Ice cream, sherbet, applesauce, water, juice
- Verify the rights of medication administration.

EYE MEDICATION (OPHTHALMIC MEDICATION)

- Administer drops (solutions) and ointments at room temperature.
- Determine the correct site for the medication—O.D. (right eye), O.S. (left eye), or O.U. (both eyes).
- Verify the rights of medication administration.
- Inform the client of the procedures.

EAR MEDICATION

- Before administering the drops, inspect the outer ear canal to be sure that wax is not blocking the opening.
- Verify the rights of medication administration.
- Administer the medication at room temperature.
- Straighten the outer ear canal by pulling the ear lobe *down and back* on children under three years old and *up and back* on clients three years old and older.

NASAL MEDICATION

NOTE: Sprays and nose drops are the most common forms of nasal medication. Sprays coat the membrane better with less waste; drops are effective with younger children.

- Before administering the medication, have the client gently blow the nose.
- Administer drops with the client's head tilted far back or with the client lying down with a pillow under the shoulders.

  NOTE: Explain to the client that he/she should stay in this position for 2-3 minutes and should not blow his/her nose for 15-20 minutes.
- Before administering a spray, shake the spray and hold the bottle upright.
- Administer sprays with the client's head erect and with one nostril blocked.
- Ask the client to inhale through the open nostril when the spray is administered.

BUCCAL MEDICATION

- Verify the rights of medication administration.
- Inform the client of the procedures.
- Place the medication between the cheek and the gum.

- Wait until the medication is completely dissolved before allowing the client to have any food or drink.

TOPICAL MEDICATION

- Verify the rights of medication administration.
- Inform the client of the procedures.
- Wear gloves to apply the medication to the skin.

  NOTE: If gloves are not available, use a clean instrument such as a tongue blade or a cotton-tipped applicator. Remember not to contaminate the remaining medication in the container.

- Rub ointments, creams, lotions, and liniments onto the skin.

  NOTE: Apply a thin covering, unless specified otherwise.

- Swab, spray or paint liquids onto the skin.
- Blow powders onto the skin from the dispensing container.

RECTAL SUPPOSITORY

- Keep handling of suppository medication to a minimum.

  NOTE: Suppository medication is designed to melt at body temperature.

- Do not remove suppositories from their foil packs until you are in the client's room.
- Provide privacy.
- Inform the client of the procedure, and the purpose of the medication.
- Give the client instructions to lay on the left side with the knee to the chest position.
- Wear gloves.

- Lubricate the suppository before inserting it into the rectum.

  NOTE: It is unnecessary to completely cover the suppository in lubricant.

- When inserting the suppository, insert it past the internal rectal sphincter about one inch.

- After administration, instruct the client to remain on the side for approximately 20 minutes.

- Assist children in holding the suppository in place by pressing the buttocks together.

VAGINAL MEDICATION

NOTE: Vaginal medications are used for local treatment of gynecological disorders. Most vaginal medications come with an applicator.

- Provide privacy.

- Be sure that the client's bladder is empty.

- Assist the client into the lithotomy position—the client should be on her back, thighs flexed on the abdomen and legs on the thighs, with the knees pointing outward.

- Be sure that the client remains lying down for ten minutes.

OBJECTIVE 10

Administer oral medication in liquid form.

INTRODUCTION

Oral medication may be a tablet, a capsule, or a liquid, and it may be given in several ways. The way it is given is not a choice for you or the resident to make; you and the resident must follow the physician's orders.

If oral medication is in liquid form, you will have to measure the liquid carefully into a medicine glass or other measuring utensil.

EQUIPMENT AND MATERIALS

- Medication (in its container)
- Medicine glass, needleless syringe, eyedropper with graduated markings, or other measuring utensil

PROCEDURE

Functional Reading Skills
- Follow written instructions

Functional Math Skills
- Make measurements

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

PREPARE TO ADMINISTER THE MEDICATION

1. Check the care plan, medical consent form and medical release form before administering any medication.
2. Wash your hands.
3. Obtain the medication in its container, and a medicine glass.
4. Verify the rights of medication administration.
5. Explain the procedure to the resident.
6. Position the resident to make swallowing easy.

♦ WARNING ♦

Review the care plan for proper positioning for the resident.

PREPARE THE DOSAGE

7. Shake liquid medication, if needed, before measuring.
8. Measure the liquid into the appropriate utensil:

Medicine glass

a. Place thumbnail on the medicine glass at the correct dosage level to mark how much liquid to pour.

b. Hold the medicine glass straight and at eye-level.

c. Pour from the side opposite the label (to avoid destroying the label).

d. Wipe the neck of the bottle, if needed, after pouring.

Oral (needleless) syringe

a. Put the tip of the syringe into the liquid medication.

b. Holding the syringe with one hand, pull back the plunger with the other hand until the liquid fills the barrel of the syringe to the correct dosage.

c. Remove the syringe from the medication.

Eyedropper with graduated markings

a. Put the tip of the eyedropper into the liquid medication and squeeze the bulb.

b. Release the bulb to fill the eyedropper to the correct dosage.

c. Remove the eyedropper from the medication.

ADMINISTER THE MEDICATION

9. Give the medication to the resident using the appropriate utensil:

Medicine glass

a. Hand the medicine glass to the resident, assisting as needed.

b. Assist the resident as needed to encourage swallowing.

NOTE: Remind residents to tilt their heads back slightly, if needed.

c. Remain with the resident until the medication is taken.

d. Remove the remaining medication and the medicine glass.

Oral (needleless) syringe or eyedropper with graduated markings

a. Place the tip of the syringe or eyedropper between the inside of the resident's cheek and the tongue.

b. Press the plunger on the syringe or the bulb on the eyedropper slowly to release the medication.

c. Assist the resident as needed to encourage swallowing.

10. Observe the resident for any side effects.

11. Document the medication.

FOLLOW UP THE MEDICATION ADMINISTRATION

12. Return the medication to its proper storage:

    a. Remove the remaining medication and all utensils.

    b. Store the medication properly.

13. Wash or dispose of the syringe or eyedropper.

14. Wash your hands.

JOB SHEET 2	ADMINISTER MEDICATION 2

OBJECTIVE 11

Administer oral medication in pill form.

INTRODUCTION

Oral medication may be a tablet (pill), a capsule, or a liquid, and it may be given in several ways. The way it is given is not a choice for you or the resident to make; you and the resident must follow the doctor's orders.

EQUIPMENT AND MATERIALS

- Medication (in its container)
- Glass of water (or fruit juice, if allowed with medication)

PROCEDURE

Functional Reading Skills
- Follow written instructions

Functional Math Skills
- Make measurements

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

PREPARE TO ADMINISTER THE MEDICATION

1. Check the care plan, medical consent form and medical release form before administering any medication.
2. Wash your hands.
3. Verify the rights of medication administration.
4. Explain the procedure to the resident.
5. Position the resident to make swallowing easy.

♦ WARNING ♦

Review the care plan for proper positioning for the resident.

PREPARE THE DOSAGE

6. Pour the correct number of tablets or capsules into the lid of the medicine container/bottle.

ADMINISTER THE MEDICATION

7. Give the resident the medication and the glass of water.
8. Instruct the resident to chew the medication (if indicated on the label).
9. Instruct the resident to swallow the medication with the water.
10. Observe the resident until the medication is swallowed.

11. Observe the resident for any side effects.

12. Document the medication.

FOLLOW UP THE MEDICATION ADMINISTRATION

13. Return the medication to its proper storage:

    a. Remove the remaining medication and all utensils.

    b. Store the medication properly.

14. Wash the empty glass.

15. Wash your hands.

JOB SHEET 3	ADMINISTER MEDICATION 2

OBJECTIVE 12

Administer eye medication.

INTRODUCTION

A number of medications are administered by placing them directly on the affected area. Eye drops, ear medications, and nasal sprays all fall into this category. Although these medications are administered outside of the body, they are still an important part of the resident care plan and should be administered with as much care as any other medication.

The most important consideration when administering eye medications is to use aseptic technique. Your hands, the medication, the dispenser, and all supplies used in giving eye medications must be free of germs. An infection of the eye can be quite dangerous and can result in loss of vision.

- Make sure any drug that you use for the eye is clearly marked "for ophthalmic use" before you administer it.
- If resident is an infant, use sterile cotton balls to help open the infant's eyelids.
- Avoid using eyecups; they can spread infection easily.

EQUIPMENT AND MATERIALS

- Medication
- Tissues
- Cotton balls
- Pillow

PROCEDURE

PREPARE TO ADMINISTER THE MEDICATION

Functional Reading Skills
- Follow written instructions

1. Check the care plan, medical consent form and medical release form before administering any medication.
2. Wash your hands.
3. Verify the rights of medication administration.

Functional Math Skills
- Make measurements

4. Explain the procedure to the resident.
5. Have the resident tilt head back.

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

ADMINISTER THE MEDICATION

6. With the forefinger or thumb of one hand, gently pull the resident's lower eyelid down.

CAUTION

Do not press on the eyeball.

7. Ask the resident to look upward (to remove the sensitive cornea from the point of instillation).

8. Approaching the resident's eye from below the resident's field of vision, hold the dropper about one inch above the eye.

NOTE: If necessary, steady your hand against the resident's forehead.

9. Place the prescribed number of drops in the center of the lower eyelid. (If you are administering ointment, place a line of ointment along the lower eyelid.)

♦ WARNING ♦

Do not allow the dispenser itself to touch the eye!

10. Ask the resident to close the eye.

11. Wipe excess drops of medication from the resident's face with a tissue.

NOTE: If the resident's eye starts to water, then blot the water. Do not rub; rubbing will irritate the eye and may wipe away needed medication.

12. Apply dressing, if needed.

13. Advise the resident not to rub the eye. (Moving the eye under the closed eyelid is alright.)

14. Observe the resident for any side effects.

15. Document the medication.

FOLLOW UP THE MEDICATION ADMINISTRATION

16. Return the medication to its proper storage:

    a. Remove the remaining medication and all utensils.

    b. Store the medication properly.

17. Clean the area.

18. Wash your hands.

JOB SHEET 4	ADMINISTER MEDICATION 2

OBJECTIVE 13

Administer ear medication.

INTRODUCTION

A number of medications are administered by placing them directly on the affected area. Eye drops, ear medications, and nasal sprays all fall into this category. Although these medications are administered outside of the body, they are still an important part of the resident's care plan and should be administered with as much care as any other medication.

- Hold or have resident hold bottle of eardrops in hands for a few minutes to warm medication to body temperature before inserting; cold eardrops can cause pain, nausea, and vomiting.

CAUTION

Do not heat the bottle in hot water, in a microwave, or on a stove. Use your hands only.

- Do not allow the dropper to touch any part of the ear.
- Do not put dropper into the ear.
- Do not use cotton ear plugs unless specified on care plan or medication label; if they are ordered, do not pack plugs tightly in the ears.

EQUIPMENT AND MATERIALS

- Medication
- Tissues
- Cotton balls
- Pillow

PROCEDURE

PREPARE TO ADMINISTER THE MEDICATION

Functional Reading Skills
- Follow written instructions

1. Check the care plan, medical consent form and medical release form before administering any medication.
2. Wash your hands.
3. Verify the rights of medication administration.

Functional Math Skills
- Make measurements

4. Explain the procedure to the resident.

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

5. Turn the resident's head so that the ear being treated faces upward.

PREPARE THE DOSAGE

6. Shake the medication, if needed.

7. If you are using a medicine dropper, place the tip of the dropper into the medication and squeeze the bulb until the medication fills the dropper to the correct dosage.

ADMINISTER THE MEDICATION

8. Pull the upper ear gently to expose the orifice.

9. Gently squeeze the bulb to release the medication against the inside wall of the canal.

10. Place a small cotton ball, if ordered, in the outer ear to cover the orifice.

    NOTE: Do not pack the cotton ball tightly into the ear.

11. Ask the resident to lie on one side for a few minutes (so the drops can reach the eardrum).

12. Observe the resident for any side effects.

13. Document the medication.

FOLLOW UP THE MEDICATION ADMINISTRATION

14. Return the medication to its proper storage.

15. Clean the area.

16. Wash your hands.

OBJECTIVE 14

Administer nasal medication.

INTRODUCTION

A number of medications are administered by placing them directly on the affected area. Eye drops, ear medications, and nasal sprays all fall into this category. Although these medications are administered outside of the body, they are still an important part of the resident's care plan and should be administered with as much care as any other medication.

- Avoid cross-contamination of germs by giving your resident nose drops only from his or her own bottle of nasal solution.
- Do not use oily nose drops for a child; the child may breathe the drops into the lungs.

EQUIPMENT AND MATERIALS

- Medication
- Tissues
- Cotton balls
- Pillow

PROCEDURE

Functional Reading Skills
- Follow written instructions

Functional Math Skills
- Make measurements

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

PREPARE TO ADMINISTER THE MEDICATION

1. Check the care plan, medical consent form and medical release form before administering any medication.
2. Wash your hands.
3. Verify the rights of medication administration.
4. Explain the procedure to the resident.
5. Ask the resident to gently blow his/her nose.
6. Have the resident lie down with shoulders on a pillow.

♦ WARNING ♦

Review the care plan for proper positioning for the resident.

PREPARE THE DOSAGE

7. Shake the medication, if needed.

8. If you are using a medicine dropper, place the tip of the dropper into the medication and squeeze the bulb until the medication fills the dropper to the correct dosage.

ADMINISTER THE MEDICATION

9. Ask the resident to breathe through the mouth while you instill the drops.

10. Hold the dispenser ⅓ to ½ inch inside the nasal passage and gently squeeze the bulb to instill the medication drop by drop.

    NOTE: Avoid touching the nostril with the dispenser, if possible.

11. Have the resident remain a few minutes with head tilted back, to allow the medication to be absorbed.

12. Advise the resident not to blow his/her nose for at least five (5) minutes.

13. Observe the resident for any side effects.

14. Document the medication.

FOLLOW UP THE MEDICATION ADMINISTRATION

15. Return the medication to its proper storage.

16. Clean the area.

17. Wash your hands.

PRACTICAL TEST 1	ADMINISTER MEDICATION 2

JOB SHEET 1

Administer oral medication in liquid form.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Prepared to administer the medication.	____	____
2. Prepared the dosage.	____	____
3. Administered the medication.	____	____
4. Followed up the medication administration.	____	____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident — Received medication only after verified rights of medication administration: resident's safety and comfort maintained throughout procedure	4	3	2	1
Medication — Medication administered correctly for the given type and form; medication prepared correctly; medication handled and stored correctly	4	3	2	1
Documentation — Required information documented immediately after medication administration	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 — Skilled — Can perform job with no additional training.
3 — Moderately skilled — Has performed job during training program; limited additional training may be required.
2 — Limited skill — Has performed job during training program; additional training is required to develop skill.
1 — Unskilled — Is familiar with process, but is unable to perform job.

PRACTICAL TEST 2	ADMINISTER MEDICATION 2

JOB SHEET 2

Administer oral medication in pill form.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Prepared to administer the medication.	____	____
2. Prepared the dosage.	____	____
3. Administered the medication.	____	____
4. Followed up the medication administration.	____	____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident — Received medication only after verified rights of medication administration; resident's safety and comfort maintained throughout procedure	4	3	2	1
Medication — Medication administered correctly for the given type and form; medication prepared correctly; medication handled and stored correctly	4	3	2	1
Documentation — Required information documented immediately after medication administration	4	3	2	1

EVALUATOR'S COMMENTS

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 — Skilled — Can perform job with no additional training.
3 — Moderately skilled — Has performed job during training program; limited additional training may be required.
2 — Limited skill — Has performed job during training program; additional training is required to develop skill.
1 — Unskilled — Is familiar with process, but is unable to perform job.

PRACTICAL TEST 3	ADMINISTER MEDICATION 2

JOB SHEET 3

Administer eye medication.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Prepared to administer the medication.	____	____
2. Administered the medication.	____	____
3. Followed up the medication administration.	____	____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident — Received medication only after verified rights of medication administration; resident's safety and comfort maintained throughout procedure	4	3	2	1
Medication — Medication administered correctly for the given type and form; medication prepared correctly; medication handled and stored correctly	4	3	2	1
Documentation — Required information documented immediately after medication administration	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 —	Skilled — Can perform job with no additional training.
3 —	Moderately skilled — Has performed job during training program; limited additional training may be required.
2 —	Limited skill — Has performed job during training program; additional training is required to develop skill.
1 —	Unskilled — Is familiar with process, but is unable to perform job.

ADMINISTER MEDICATION

JOB SHEET 4

Administer ear medication.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Prepared to administer the medication.	_____	_____
2. Prepared the dosage.	_____	_____
3. Administered the medication.	_____	_____
4. Followed up the medication administration.	_____	_____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident — Received medication only after verified rights of medication administration; resident's safety and comfort maintained throughout procedure	4	3	2	1
Medication — Medication administered correctly for the given type and form; medication prepared correctly; medication handled and stored correctly	4	3	2	1
Documentation — Required information documented immediately after medication administration	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 — Skilled — Can perform job with no additional training.
3 — Moderately skilled — Has performed job during training program; limited additional training may be required.
2 — Limited skill — Has performed job during training program; additional training is required to develop skill.
1 — Unskilled — Is familiar with process, but is unable to perform job.

PRACTICAL TEST 5	ADMINISTER MEDICATION 2

JOB SHEET 5

Administer nasal medication.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Prepared to administer the medication.	_____	_____
2. Prepared the dosage.	_____	_____
3. Administered the medication.	_____	_____
4. Followed up the medication administration.	_____	_____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident — Received medication only after verified rights of medication administration; resident's safety and comfort maintained throughout procedure	4	3	2	1
Medication — Medication administered correctly for the given type and form; medication prepared correctly; medication handled and stored correctly	4	3	2	1
Documentation — Required information documented immediately after medication administration	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 — Skilled — Can perform job with no additional training.
3 — Moderately skilled — Has performed job during training program; limited additional training may be required.
2 — Limited skill — Has performed job during training program; additional training is required to develop skill.
1 — Unskilled — Is familiar with process, but is unable to perform job.

NAME _____ SCORE _____

OBJECTIVE 1

Verify rights of medication administration. State the rights in the spaces below.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

OBJECTIVE 2

Explain the importance of factors in a resident's personal medical history (to be considered before administering medication). Explain any six (6) of the factors listed.

- Allergies
- Age
- Body build
- Diagnosis
- Drug tolerance
- Emotional state
- Indication
- Physical state
- Present symptoms

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

OBJECTIVE 3 **State the checkpoints for verifying a medication during preparation.**

1. _____

2. _____

3. _____

OBJECTIVE 4 **Identify forms of medications.** Write the correct letter in each blank.

I = Inhalant
M = Mucosal
O = Oral
R = Rectal
T = Topical

_____1. Capsule

_____2. Tablet

_____3. Time-release capsule

_____4. Suspension

_____5. Suppository

_____6. Transdermal patch

_____7. Ointment

_____8. Liniment

_____9. Buccal tablet

_____10. Sublingual tablet

_____11. Eye, ear and nose drops

_____12. Spray (or mist)

OBJECTIVE 5

Match common medications to their predominant side effects.
Write the correct letter in each blank.

_____1. Visual disturbances and headaches

_____2. Abdominal discomfort (pain and distention), belching and flatulence (gas) is frequently seen

_____3. Extra-pyramidal symptoms

_____4. Nausea and vomiting may occur

_____5. Flu-like symptoms may appear

_____6. Lowering of blood pressure when the resident gets up

_____7. Side effects are dependent on how the particular medication works

_____8. Dry mouth, blurred vision, irregular heartbeats

_____9. Phenobarbital can cause a slowing of respirations, as well as dizziness and drowsiness

a. Vascular and cardiac agents

b. Diuretics

c. Nitrates

d. Antihypertensives

e. Neuroses and psychoses

f. Antipsychotic agents

g. Anticonvulsants

h. Antiarthritic and antigout agents

i. New medications (Prozac, Colestid and Questran, Mevacor, Ansaid)

_____10. Most common side effects are related to the gastrointestinal tract such as nausea with or without vomiting, diarrhea, or constipation and abdominal cramps and pain

_____11. Loss of appetite and significant weight loss in some people

_____12. Often decrease the amount of potassium in the resident

OBJECTIVE 6

Identify requirements for properly storing and handling medications. Write an "X" in the blank beside each requirement.

_____1. Store insulin, liquid antibiotics and suppositories in a warm place.

_____2. Be sure that any medication in a suspension form is "shaken well."

_____3. Take note of the expiration date on all medications.

_____4. Keep all medications in their original container showing the resident's first and last name.

_____5. Keep a bulk supply of medications.

_____6. Lock all medications and double-lock narcotics.

_____7. Store medications with non-drug items.

_____8. Store medications applied externally separately from medications taken internally.

OBJECTIVE 7

State requirements for storing, using and documenting a controlled drug.

1. _____

_____

2. _____

_____

3. _____

_____

OBJECTIVE 8

Identify the documentation necessary when administering medication. Write an "X" in the blank beside each required item of information.

_____1. Resident's first and last name

_____2. Resident's temperature

_____3. Name of the medication

_____4. Dosage or amount of the medication to be administered

_____5. Route of administration

_____6. Expiration date of the medication

_____7. Required daily frequency of administration

_____8. Any special orders

OBJECTIVE 9

Select from a list guidelines for preparing client medication for transport to a workshop. Write an "X" in the blank beside each guideline.

_____1. Place all medications for each client in a single medication bottle for that client.

_____2. Make sure that the label states the name of the medication, its strength, the route the medication is to be administered, the number that must be taken, and the frequency the medication is to be taken.

_____3. Place the medication bottle(s) in a container such as a zip-lock bag or a box that has been labeled with the client's first and last name.

NOTICE

The following objectives are not a part of this written test. If you have not completed these activities, check with your instructor.

OBJECTIVE 10	**Administer oral medication in liquid form.**	RATING _____
OBJECTIVE 11	**Administer oral medication in pill form.**	RATING _____
OBJECTIVE 12	**Administer eye medication.**	RATING _____
OBJECTIVE 13	**Administer ear medication.**	RATING _____
OBJECTIVE 14	**Administer nasal medication.**	RATING _____

OBJECTIVE 1

In any order:

- Right resident
- Right time and date
- Right medication
- Right dosage
- Right dosage form
- Right route of administration

OBJECTIVE 2

Any six (6) of the following:

- **Allergies** — All residents should be asked about drug allergies and caution should be used if this is the resident's first time for this medication.
- **Age** — Age affects the rate in which the body metabolizes the medication. Older adults metabolize medication slowly; infants and children may metabolize medication very rapidly.
- **Body Build** — Body weight, as well as the percentage of body fat and muscle tissue affects the metabolizing of medication.
- **Diagnosis** — Diseases may change the way medication works.
- **Drug tolerance** — Tolerance can be assessed only after the medication has been given. You should be aware of the resident's reaction to the medication if it was given previously. Drug tolerance changes during the aging process.
- **Emotional state** — The emotional state of the resident may affect how that person perceives the medication and how effective the medication is for treating the illness.
- **Indication** — You should know the reasons for a particular resident receiving a medication.
- **Physical state** — A resident's physical ability to tolerate a drug or the route being used. A resident who is vomiting cannot take medication orally, so a change in route must be made.
- **Present symptoms** — Some symptoms may indicate drug toxicity or other contraindications to giving that medication or may indicate the need for more effective medication.

OBJECTIVE 3

In any order:

- When you obtain the medication from the storage area.
- While you are pouring the medication.
- When you return the medication to the proper storage area.

OBJECTIVE 4

1.	O	7.	T
2.	O	8.	T
3.	O	9.	M
4.	O	10.	M
5.	R	11.	M
6.	T	12.	I

OBJECTIVE 5

1.	a	7.	d
2.	i	8.	e
3.	f	9.	g
4.	c	10.	h
5.	a	11.	i
6.	c	12.	b

OBJECTIVE 6

2, 3, 4, 6, 8

OBJECTIVE 7

In any order:

- Double-lock all narcotics.
- Take a complete count of all narcotics at the beginning and end of each shift.
- Record the following information each time a client is administered a dose of a controlled drug: client's name, exact date and time, name of the medication, amount given and route given, name of doctor(s) ordering the medication, name of person administering the medication, amount (number) of the medication remaining in the container

OBJECTIVE 8

1, 3, 4, 5, 7, 8

OBJECTIVE 9

2, 3

OBJECTIVE SHEET	**OBTAIN VITAL SIGNS** 3

INTRODUCTION

Vital signs include temperature, pulse, respiration, and blood pressure. Obtaining the vital signs of a resident will help to detect any change in the resident's normal body functions. When the body is not functioning normally, measurable changes happen in the vital signs. This change can help to detect illness or a disease process. It will also help to show the success of a medical treatment. *Vital signs can indicate a minor change or a life-threatening situation.* As a MAT, you may have to obtain and chart vital signs. Because of their importance, vital signs must be accurately measured, reported, and charted.

UNIT OBJECTIVE

After completing this unit, you should be able to obtain and chart the vital signs: temperature, pulse, respiration and blood pressure. You will demonstrate these competencies by completing job sheets and by completing the Written Test with a minimum of eighty-five percent (85%) accuracy.

PREREQUISITES

Before studying this unit, you should have successfully completed the *Medication Administration Technician* training program.

SPECIFIC OBJECTIVES

After completing this unit, you should be able to

1. Match terms associated with vital signs to their correct definition.
2. Write the symbols for charting vital signs.
3. State guidelines for reading a mercury thermometer.
4. State two items that the pulse rate identifies.
5. Locate the pulse points on the human body.
6. Explain blood pressure.
7. Chart vital signs. (Assignment Sheet 1)
8. Read a mercury thermometer. (Assignment Sheet 2)
9. Convert Fahrenheit and Centigrade (Celsius) temperature readings. (Assignment Sheet 3)

10. Read sphygmomanometer gauges. (Assignment Sheet 4)

11. Clean a mercury thermometer. (Job Sheet 1)

12. Shake down a mercury thermometer. (Job Sheet 2)

13. Take an oral temperature using a mercury thermometer. (Job Sheet 3)

14. Take a radial pulse rate and respiratory rate. (Job Sheet 4)

15. Take blood pressure. (Job Sheet 5)

PREPARATION

- Order additional materials to supplement this unit.
- Review the unit and plan your presentation:
  - — Estimate the amount of material that can be covered in each class session.
  - — Identify objectives that you can supplement with other resources.
  - — Invite guest speakers in advance.
- Design transparencies and handouts to reinforce the objectives in each unit, to provide additional information, or to facilitate in-class activities.
- Arrange for any needed demonstrations and accompanying media.
- Arrange for any needed equipment and materials for student practice.

DELIVERY

Objective 1

- Discuss each of the terms. Provide examples of thermometer types and sphygmomanometers, if possible.

Objective 2

- Review the need for correct documentation.
- Give examples of other ways in which the vital signs could be charted.
- Review Supplement 1. Discuss the proper procedure for the MAT to follow, should any of a resident's vital signs be outside the normal range.
- Have students complete Assignment Sheet 1.

Objective 3

- Discuss the importance of each guideline.

- Discuss the difference between Fahrenheit and Centigrade (Celsius) temperature scales. Have students complete Assignment Sheet 2.

- Show the correct way to hold and read a thermometer.

- Convert temperature readings. Work through examples from Fahrenheit to Centigrade (Celsius) and from Centigrade (Celsius) to Fahrenheit. Have students complete Assignment Sheet 3.

- Demonstrate the correct way to clean a mercury thermometer. Introduce Job Sheet 1.

- Demonstrate the correct way to shake down a mercury thermometer. Introduce Job Sheet 2.

- Demonstrate the proper procedures for taking temperatures. Introduce Job Sheet 3. Discuss Supplement 2 and Supplement 3.

Objectives 4 and 5

- Discuss factors that influence pulse rates and respiratory rates.

- Demonstrate the proper procedures for taking pulse rates and respiratory rates. Have students check their own pulse rates and respiratory rates.

- Introduce Job Sheet 4.

Objective 6

- Discuss factors that influence blood pressure.

- Display different types of sphygmomanometers. Demonstrate the correct way to read aneroid and mercury types. Have students complete Assignment Sheet 4.

- Explain common errors in taking blood pressure: point out how to avoid these errors.

- Introduce Job Sheet 5.

APPLICATION

Objectives 7 through 10

- Have students complete each Assignment Sheet as an in-class or take-home activity after discussing the related unit objectives.
- Review the related unit objectives for each Assignment Sheet, if needed.
- Create additional Assignment Sheets, as needed, to reinforce the unit objectives and/or to meet the needs of students.
- Evaluate students on Assignment Sheet activities.

Objectives 11 through 15

- Demonstrate the procedures for each Job Sheet.
- Have students practice each Job Sheet until they are ready to be evaluated on the Practical Test for each Job Sheet procedure.
- Schedule students for taking Practical Tests.

EVALUATION

Practical Test

- Explain to students that they will be asked to demonstrate procedures on the Job Sheets to complete the Practical Tests.
- Describe the rating scale used on the Practical Test.
- Reteach and retest as necessary.
- Counsel students individually on the results of their Practical Tests.

Written Test

- Give the Written Test soon after presenting the unit.
- Remind students throughout your presentation that the questions and required performance on each Written Test match the Specific Objectives stated at the beginning of the unit and the objectives discussed in the unit.

- Review individual and group performance in order to evaluate teaching methods. Adjust your approach as needed.

UNIT REFERENCES

- Curriculum and Instructional Materials Center. *Medication Administration Technician*. Oklahoma Department of Vocational and Technical Education. Stillwater, Oklahoma. 1989.

INFORMATION SHEET	OBTAIN VITAL SIGNS 3

OBJECTIVE 1

Match terms associated with vital signs to their correct definition.

- **Aneroid** — A dial-type of pressure gauge without mercury, used in some sphygmomanometers
- **Axillary** — Relating to the armpit; a temperature is taken by placing the thermometer snugly in the armpit
- **Blood pressure** — The force of blood pushing against the walls of blood vessels, recorded in millimeters of mercury (mmHg); the reading includes the systolic pressure (top number) and the diastolic pressure (bottom number)
- **Calibration** — The lines on the scale of a thermometer, at intervals of two-tenths of a degree on a Fahrenheit thermometer and one-tenth of a degree on a Centigrade (Celsius) thermometer
- **Centigrade (Celsius)** — A temperature scale having zero degrees as the freezing point and 100 degrees as the boiling point
- **Diastolic pressure** — The amount of pressure against the walls of blood vessels when the heart relaxes between each beat; recorded as the bottom number of the blood pressure reading
- **Fahrenheit** — A temperature scale having 32 degrees as the freezing point and 212 degrees as the boiling point
- **Oral** — Relating to the mouth; a temperature is taken by placing the thermometer in the mouth and under the tongue
- **Pulse** — A measurement of how fast the heart is beating
- **Radial** — Relating to the wrist
- **Rectal** — Relating to the rectum; a temperature is taken by inserting the thermometer gently into the anus
- **Respiration** — The act of breathing in (inspiration) and breathing out (expiration)

- **Sphygmomanometer** — An instrument used for measuring blood pressure

- **Systolic pressure** — The amount of pressure against the walls of blood vessels when the heart is contracting or forcing the blood through the vessels; recorded as the top number of the blood pressure reading

OBJECTIVE 2 **Write the symbols for charting vital signs.**

Blood pressure = B.P.

Centigrade Celsius = C

Degree =

Fahrenheit = F

Temperature = T.

NOTE: Your employer may require that you indicate the *method* when charting a temperature reading, such as "Ax." for axillary, "R." for rectal, or "O." for oral.

Pulse = P.

Respiration = R.

OBJECTIVE 3 **State guidelines for reading a mercury thermometer.**

- Hold the thermometer by the stem at eye level.

  NOTE: Always hold a mercury thermometer by the stem, not by the bulb end that holds the mercury. If you hold the thermometer by the bulb end, your own body heat could affect the temperature reading and your hands could contaminate the clean bulb.

- Turn the thermometer slowly between your thumb and index finger until you can see the column of mercury clearly.

  NOTE: ACCURACY IS EXTREMELY IMPORTANT. LOOK AT THE MERCURY CAREFULLY WHEN READING A MERCURY THERMOMETER.

- When reading a Fahrenheit thermometer, count two-tenths of a degree (0.2) between each calibration.

- When reading a Centigrade (Celsius) thermometer, count one-tenth of a degree (0.1) between each calibration.

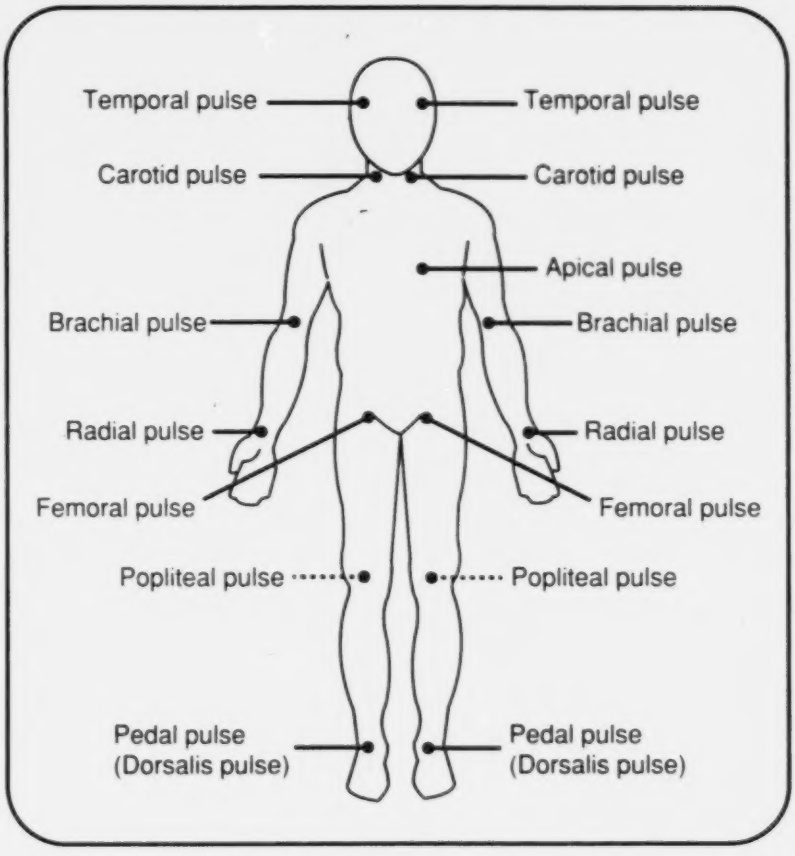
OBJECTIVE 4

State two items that the pulse rate identifies.

- The rate — how many times the heart beats per minute

- The rhythm — how regular or irregular the heart beats

OBJECTIVE 5 **Locate the pulse points on the human body.**



Used with permission of The Hospital Research and Educational Trust, from *Being a Nursing Assistant*, fourth edition. 1986.

OBJECTIVE 6

Explain blood pressure.

Blood pressure is the force of blood pushing against the walls of blood vessels. When you take a resident's blood pressure, you are measuring the force of the blood flowing through the arteries. The heart, by pumping, is constantly forcing the blood to circulate throughout the body. The pressure in the arteries depends on the rate of the heartbeat and on how easily the blood flows through the blood vessels. Blood pressure is at its highest (systolic pressure) when the heart is contracting or forcing the blood through the vessels; it is at its lowest (diastolic pressure) when the heart relaxes between each beat.

NORMAL READINGS FOR VITAL SIGNS

TEMPERATURE			
	Oral	Rectal	Axillary
FAHRENHEIT	98.6	99.6	97.6
CENTIGRADE	37.0	37.5	36.4

PULSE (normal rates per minute)	
Childhood	80-115
Adult years	72-80
Later years	60-70

Source: Used with permission of The Hospital Research and Educational Trust, from *Being a Nursing Assistant*, fourth edition, © 1986.

RESPIRATIONS (per minute)	
Adults	14-20
Children	Faster
Elderly	Slower

UPPER LIMITS OF NORMAL BLOOD PRESSURE IN CHILDREN

AGE	SYSTOLIC	DIASTOLIC
5	106	60
6	108	66
7	108	70
8	110	70
9	114	76
10	118	76
11	124	78
12	128	78
13	132	80
14	136	80
15	140	80
16	140	80
17	140	80
18	140	80

BLOOD PRESSURE IN ADULTS AGE 18 YEARS OR OLDER[1]

Range, mm Hg	Category [2]
Diastolic	
<85	Normal blood pressure
85-89	High normal blood pressure
90-104	Mild hypertension
105-114	Moderate hypertension
≥115	Severe hypertension
Systolic, when diastolic blood pressure is <90	
<140	Normal blood pressure
140-159	Borderline isolated systolic hypertension
≥160	Isolated systolic hypertension

1 Classification based on the average of two or more readings on two or more occasions.

2 A classification of borderline isolated systolic hypertension (SBP 140 to 159 mm Hg) or isolated systolic hypertension (SBP ≥160 mm Hg) takes precedence over high normal blood pressure (diastolic blood pressure, 85 to 89 mm Hg) when both occur in the same person. High normal blood pressure (DBP 85 to 89 mm Hg) takes precedence over a classification of normal blood pressure (SBP <140 mm Hg) when both occur in the same person.

Source: The 1988 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. NIH Publication No. 88-1088. May 1988.

TAKING A RECTAL TEMPERATURE USING A MERCURY THERMOMETER

INTRODUCTION

Before taking a rectal temperature, determine the most comfortable way to position the resident on his or her side. The resident may have special problems requiring special consideration, such as a weakened side, sores, or tubes and other equipment.

If the resident is a child, you must also determine whether the child is familiar with the rectal method and whether there have been any special problems using this method.

EQUIPMENT AND SUPPLIES

- Mercury thermometer *marked Rectal*
- Watch with a second hand
- Clean tissue
- Lubricant
- Paper and pen
- Clean, disposable gloves

PROCEDURE

1. Wash your hands.
2. Check the thermometer:
   a. Make sure that the thermometer is a rectal thermometer.
   b. Make sure that the thermometer is not chipped or cracked.
   c. Make sure that the thermometer has been properly cleaned.
3. Explain the procedures to the resident.
4. Put on disposable gloves.
5. Shake the thermometer down.
6. Lubricate the bulb of the thermometer, using a small amount of lubricant on a tissue.

7. Turn back the covers or clothing just enough to see the rectal area.

   NOTE: Provide privacy. Avoid exposing the resident any more than necessary.

8. Insert the thermometer:

   a. Raise the upper buttock to expose the anus.

   b. Insert the lubricated bulb gently into the rectum 1 inch to 1½ inches (for an adult).

9. Remaining with the resident, keep the thermometer in place for 2-4 minutes.

   ♦ WARNING ♦

   Never leave the resident while taking a rectal temperature. If the resident moves while the thermometer is not being held, injury could result.

10. Carefully remove the thermometer and wipe it from the stem to the bulb with clean tissue.

11. Record the temperature on paper.

    NOTE: Remember to write "R." to indicate a rectal temperature.

12. Clean the rectal area with clean tissue.

    NOTE: If the resident is female, wipe from front to back, away from the vagina.

13. Make the resident comfortable.

14. Shake the thermometer down.

15. Clean the thermometer.

16. Clean the area and return equipment and supplies to their proper storage:

    a. Throw away the used tissues.

b. Throw away the disposable gloves.

c. Return the thermometer to its holder.

17. Wash your hands.

18. Chart the temperature reading on the resident's care plan.

NOTE: Report any changes from normal temperature to your supervisor.

TAKING AN AXILLARY TEMPERATURE USING A MERCURY THERMOMETER

INTRODUCTION

Taking an axillary temperature is an alternative to taking an oral or rectal temperature. It is the *safest but least reliable* method of obtaining body temperature.

EQUIPMENT AND SUPPLIES

- Mercury thermometer (oral or rectal)
- Watch with a second hand
- Clean tissue
- Paper and pen

PROCEDURE

1. Wash your hands.
2. Check the thermometer:
   a. Make sure that the thermometer is not chipped or cracked.
   b. Make sure that the thermometer has been properly cleaned.
3. Explain the procedure to the resident.
4. Assist the resident to a sitting or lying position.
5. Expose the resident's arm up to the armpit.
6. Pat the armpit dry with tissue (if needed).

   NOTE: Avoid excessive rubbing of the armpit; this will create heat which will affect the temperature reading.
7. Shake the thermometer down.
8. Place the thermometer in the armpit with the mercury tip pointing slightly upward toward the shoulder.
9. Place the resident's arm across the chest or abdomen to hold the thermometer in place.
10. Remaining with the resident, keep the thermometer in place for 10 minutes.

11. Carefully remove the thermometer and wipe it from the stem to the bulb with clean tissue.

12. Record the temperature on paper.

    NOTE: Remember to write "ax." to indicate an axillary temperature.

13. Make the resident comfortable.

14. Shake the thermometer down.

15. Clean the thermometer.

16. Clean the area and return equipment and supplies to their proper storage.

17. Wash your hands.

18. Chart the temperature reading on the resident's care plan.

    NOTE: Report any changes from normal temperature to your supervisor.

NAME _____ SCORE _____

OBJECTIVE 7

Chart vital signs.

INTRODUCTION

Because of their importance, vital signs must be accurately measured, reported, and charted. Your employer may have more specific procedures to follow.

DIRECTIONS

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

Functional Writing Skills
- Complete forms and records

- Read each paragraph.
- Chart the vital signs by writing them in the blank below each paragraph.
  - — Write the vital signs in this order: temperature, pulse, respiration, and blood pressure.
  - — Use the correct symbols.
  - — Separate each vital sign by a comma.

    EXAMPLE: T. 98.8°F, P. 84, R. 18, B/P 120/76

1. A resident has a temperature of 99.8 degrees, taken with a Fahrenheit thermometer. The resident's pulse is 71 beats per minute. The respiratory rate is 18. The diastolic pressure is 86; the systolic pressure is 150.

   _____

2. You have just taken a resident's temperature using a mercury thermometer with a Centigrade (Celsius) scale. As you read the thermometer, you note that the mercury is three calibrations above the 38-degree marking. The resident's pulse is 80 beats per minute and the respiratory rate is 18. The blood pressure is 120 over 76.

   _____

3. A resident has a pulse rate of 64. The resident's blood pressure is 130 over 80. While taking the resident's pulse, you counted the resident breathing in and out 17 times in one full minute. Holding the thermometer by the stem at eye level, you note that the mercury is 3 calibrations above the 98-degree marking.

_____

4. A resident has a temperature of 100.2 degrees, taken with a Fahrenheit thermometer. The resident's pulse is 69 beats per minute. The resident breathes in and out 16 times in one full minute. The systolic pressure is 180; the diastolic pressure is 90.

_____

NAME _____ SCORE _____

OBJECTIVE 8

Read a mercury thermometer.

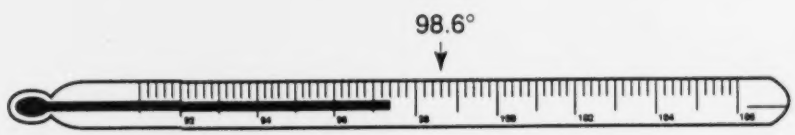
INTRODUCTION

Accuracy is extremely important when taking a temperature. You must look at the thermometer carefully and be able to determine the correct temperature on a Fahrenheit thermometer and on a Centigrade (Celsius) thermometer.

DIRECTIONS

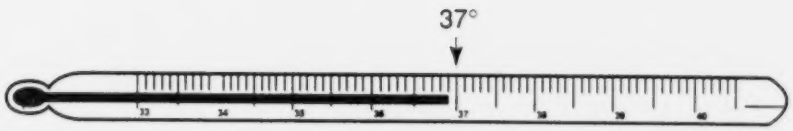
Functional Math Skills
- Make measurements

- Determine the temperature shown on each thermometer drawing.
  - — When reading a Fahrenheit thermometer, count two-tenths of a degree (0.2) between each calibration.
  - — When reading a Centigrade (Celsius) thermometer, count one-tenth of a degree (0.1) between each calibration.
- Write the correct temperature in the blank below each drawing. Be sure to identify the correct type of thermometer in each answer, Fahrenheit or Centigrade.

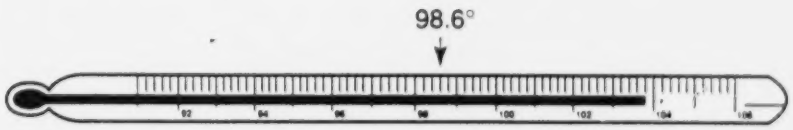


1. _____

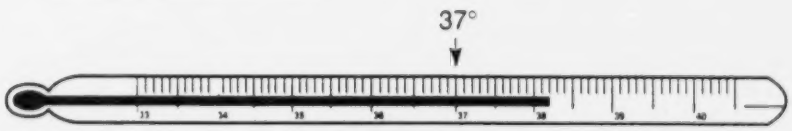
2. _____



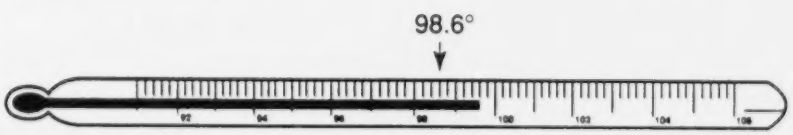
3. _____



4. _____



5. _____



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NAME _____ SCORE _____

OBJECTIVE 9

Convert Fahrenheit and Centigrade (Celsius) temperature readings.

INTRODUCTION

Mercury thermometers may have a Fahrenheit scale or a Centigrade (Celsius) scale. By knowing how to convert temperatures from Fahrenheit to Centigrade or from Centigrade to Fahrenheit, you can compare temperature readings taken with two different scales.

DIRECTIONS

Operation and Calculation Skills
- Calculate with fractions
- Convert units of measure
- Calculate with decimals

Math Application Skills
- Solve word problems

- To convert a temperature from Centigrade to Fahrenheit, multiply the degrees Centigrade by 9/5 and add 32.
- To convert a temperature from Fahrenheit to Centigrade, subtract 32 from the degrees Fahrenheit and multiply by 5/9.

1. 98.0°F = _____
2. 38.1°C = _____
3. 100.2°F = _____
4. 39.5°C = _____
5. 96.8°F = _____
6. 37.3°C = _____
7. If one resident has a temperature of 96.8°F and another resident has a temperature of 37.5°C, which resident has the higher temperature?

   _____
8. If a resident has a temperature of 37.0°C at 8 a.m. and a temperature of 99.8°F at 8 p.m., has the resident's temperature changed?

   _____

OBTAIN VITAL SIGNS

NAME _____ SCORE _____

OBJECTIVE 10

Read sphygmomanometer gauges.

INTRODUCTION

A sphygmomanometer is an instrument used for measuring blood pressure. A sphygmomanometer can be a *mercury type* or an *aneroid (dial) type*. When using a mercury type to measure blood pressure, you must note the level of a column of mercury on a scale; when using an aneroid type, you must note the pointer on a dial. On both types, the calibrations are two millimeters of mercury (2 mmHg) apart. Calibrations are numbered every ten mmHg.

DIRECTIONS

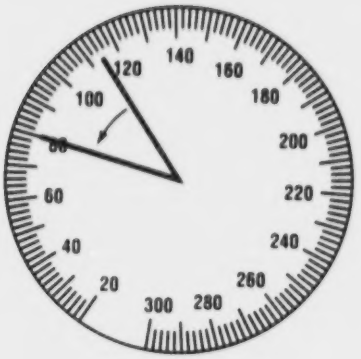
Functional Math Skills
- Make measurements

- Be familiar with the calibrations on aneroid and mercury sphygmomanometers. *On both types*, the calibrations are two millimeters of mercury (mmHg) apart. *On the aneroid type*, calibrations are numbered every 20 mmHg; *on the mercury type*, calibrations are numbered every 10 mmHg.

- Observe the manometer gauge at eye level when the first strong pulse is heard. This is the systolic pressure. Observe the manometer gauge at eye level when the last distinct loud sound is heard. This is the diastolic pressure. On the following illustrations of aneroid gauges, the direction of movement of the arrow indicates the first strong pulse and the last distinct loud sound; on the mercury gauges, the top and the bottom of the shaded area indicates the first and last sounds.

- Write the blood pressure shown in each illustration.

  EXAMPLE: 112/76



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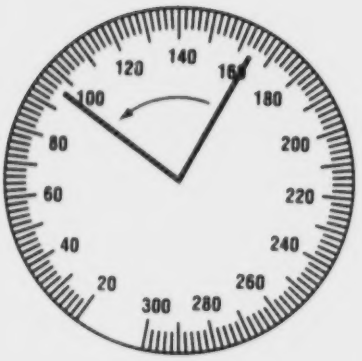

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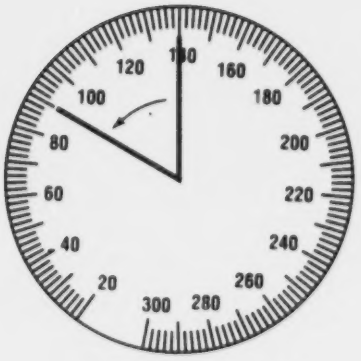

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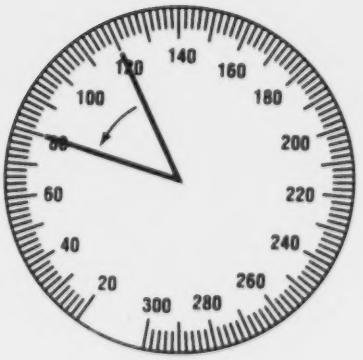
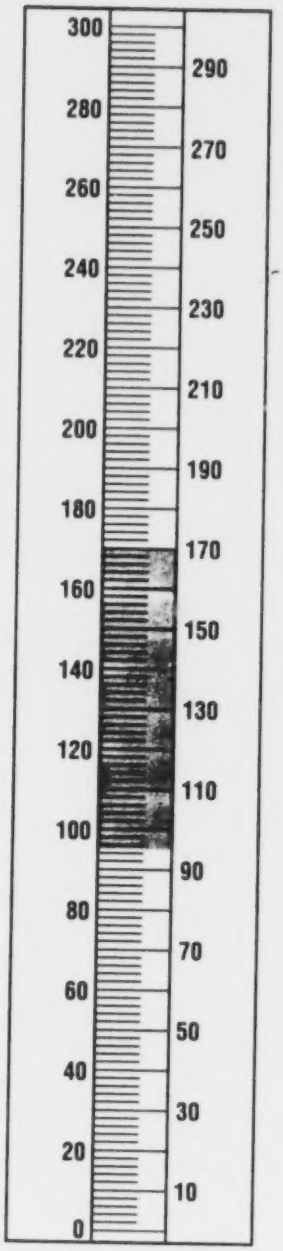


4. BP = _____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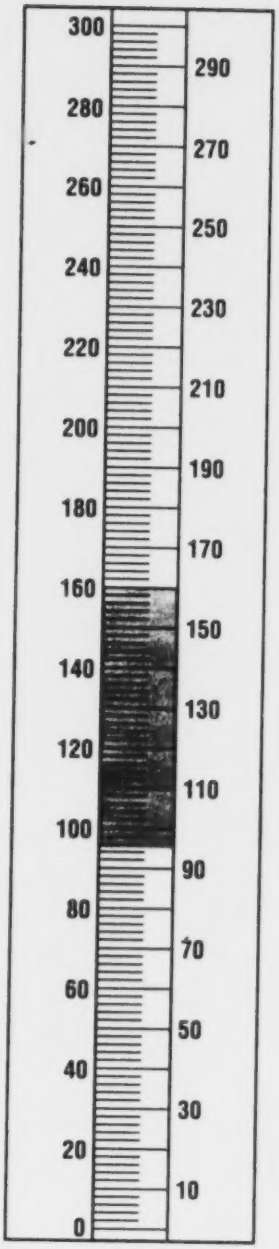
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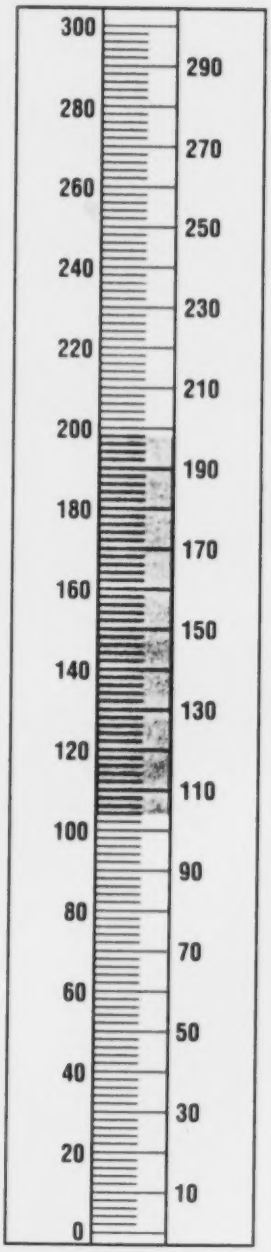
5. BP = _____

6. BP = _____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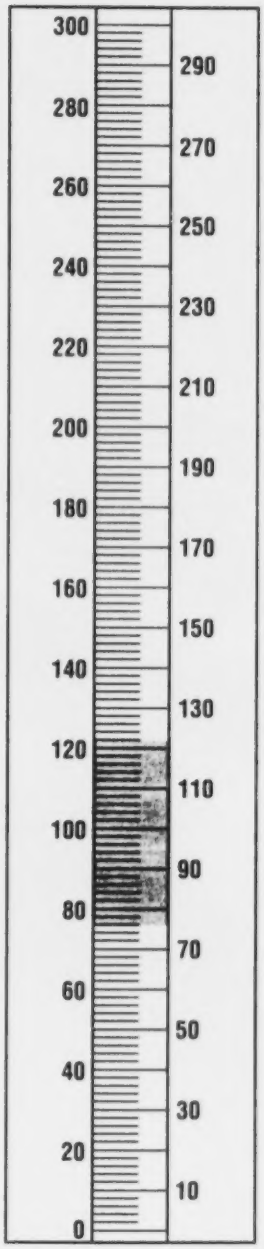
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7. BP = _____

8. BP = _____

ASSIGNMENT SHEET 1

1. T. 99.8°F, P. 71, R. 18, B/P 150/86
2. T. 38.3°C, P. 80, R. 18, B/P 120/76
3. T. 98.6°F, P. 64, R. 17, B/P 130/80
4. T. 100.2°F, P. 69, R. 16, B/P 180/90

ASSIGNMENT SHEET 2

1. 97.4°F
2. 37.3°C
3. 36.9°C
4. 103.8°F
5. 38.2°C
6. 99.6°F

ASSIGNMENT SHEET 3

1. 36.7°C
2. 100.6°F
3. 37.9°C
4. 103.1°F
5. 36.0°C
6. 99.1°F
7. The resident with a temperature of 37.5°C (equivalent to a temperature of 99.5°F).
8. Yes, the resident's temperature has increased from 98.6°F (37.0°C) to 99.8°F.

ASSIGNMENT SHEET 4

1. 114/80
2. 164/96
3. 140/90
4. 120/80
5. 170/95
6. 160/95
7. 198/104
8. 122/76

OBJECTIVE 11

Clean a mercury thermometer.

INTRODUCTION

Your employer may have a special method that you must follow for cleaning a thermometer. This procedure may include washing the thermometer, disinfecting it, then storing the thermometer in an antiseptic solution. If your employer does not have a special method, then you can clean the thermometer with soap and cool water.

EQUIPMENT AND SUPPLIES

- Mercury thermometer
- Soap
- Cool tap water
- Cotton balls
- Antiseptic solution (for disinfecting and/or storing the thermometer)
- Two small basins

PROCEDURE

Functional Reading Skills
- Follow written instructions

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

1. Wash your hands.

2. Fill one basin with *cool* water and soap.

CAUTION

Never use warm water or hot water to clean a mercury thermometer.

3. Wash the thermometer:

   a. Place the thermometer in the soapy water.

   b. Using cotton balls, wipe the thermometer from the stem downward to the bulb.

      NOTE: Always hold a mercury thermometer by the stem, not by the bulb end that holds the mercury. If you hold the thermometer by the bulb end, your own body heat could affect the temperature reading and your hands could contaminate the clean bulb.

   c. Rinse the thermometer in *cool* water.

d. If you are not going to disinfect the thermometer, then dry the thermometer with clean, dry cotton balls. Go to Step 5.

4. Disinfect the thermometer:

   a. Place the thermometer in a basin of antiseptic solution.

   b. Remove the thermometer from the solution and rinse the thermometer with *cool* water.

   c. Dry the thermometer with clean, dry cotton balls.

5. Return the thermometer to its case or store it in a container with antiseptic solution.

6. Clean the area and return equipment and supplies to their proper storage.

7. Wash your hands.

OBJECTIVE 12

Shake down a mercury thermometer.

INTRODUCTION

The mercury in a mercury thermometer will stay at its last reading until someone shakes the thermometer. To obtain an accurate temperature reading, you must shake the thermometer to make sure that the mercury level is lower than the resident's body temperature at the start of the procedure. You should shake down the thermometer before and after each use.

EQUIPMENT AND SUPPLIES

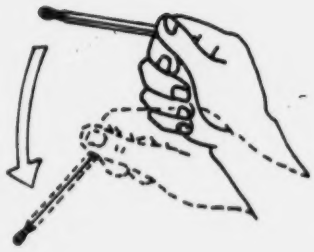
- Mercury thermometer

PROCEDURE

Functional Reading Skills
- Follow written instructions

1. Wash your hands.
2. Hold the thermometer by the stem between your thumb and index finger.

   NOTE: Always hold a mercury thermometer by the stem, not by the bulb end that holds the mercury. If you hold the thermometer by the bulb end, your own body heat could affect the temperature reading and your hands could contaminate the clean bulb.
3. Check the thermometer to make sure that it is not chipped or cracked.
4. Check the area around you to make sure that you will not hit anything when shaking the thermometer.
5. Shake the thermometer by snapping your wrist downward, as if you are shaking water from your fingers.



6. Continue shaking the thermometer until the mercury level is below 95.0°F.

JOB SHEET 3	OBTAIN VITAL SIGNS 3

OBJECTIVE 13

Take an oral temperature using a mercury thermometer.

INTRODUCTION

Taking an oral temperature is probably the most common way of determining body temperature. The tip of the thermometer measures the body's internal temperature under the tongue, where blood vessels are close to the surface. The mouth is also easy to reach without requiring the resident to remove any clothing.

EQUIPMENT AND SUPPLIES

- Mercury thermometer
- Watch with a second hand
- Clean tissue
- Paper and pen
- Clean, disposable gloves (optional)
- Plastic thermometer covers (optional)

PROCEDURE

Functional Reading Skills
- Follow written instructions

Functional Math Skills
- Make measurements

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

1. Wash your hands.
2. Make sure that the thermometer has been properly cleaned.
3. Explain the procedure to the resident.
4. Assist the resident to a sitting or lying position.
5. Put on disposable gloves (optional).
6. Shake the thermometer down.
7. Rinse the bulb of the thermometer under *cool* water to remove the antiseptic solution and to moisten the tip, or place a plastic cover over the thermometer.
8. Gently place the bulb end under the resident's tongue; ask the resident to keep lips closed without biting the thermometer.
9. Remaining with the resident, keep the thermometer in place for 2-3 minutes.
10. Carefully remove the thermometer and either wipe it from the stem to the bulb with clean tissue, or remove and discard the plastic cover.

11. Record the temperature on paper.

    NOTE: Report any temperature reading above 104.0°F to your supervisor. A physician may have to be called and steps taken to lower the body temperature. Report any change from the normal temperature to your supervisor.

12. Make the resident comfortable.

13. Shake the thermometer down.

14. Clean the thermometer.

15. Clean the area and return equipment and supplies to their proper storage:

    a. Throw away the disposable gloves.

    b. Return the thermometer to its case or store it in antiseptic solution.

16. Wash your hands.

17. Chart the temperature reading on the resident's care plan.

    NOTE: Report any changes from normal temperature to your supervisor.

OBJECTIVE 14

Take a radial pulse rate and respiratory rate.

INTRODUCTION

When you take a resident's pulse, you can identify (1) the *rate,* or how many times the heart beats per minute, and (2) the *rhythm,* or how regular or irregular the heart beats. The body has certain points where the pulse can be easily felt with your finger. One of the easiest points is at the wrist, which is the radial artery. The carotid pulse can also be easily felt.

EQUIPMENT AND SUPPLIES

- Watch with a second hand
- Paper and pen

PROCEDURE

1. Wash your hands.
2. Explain the procedure to the resident.
3. Place the resident's arm in a comfortable position at heart level. (See Figure 1.)

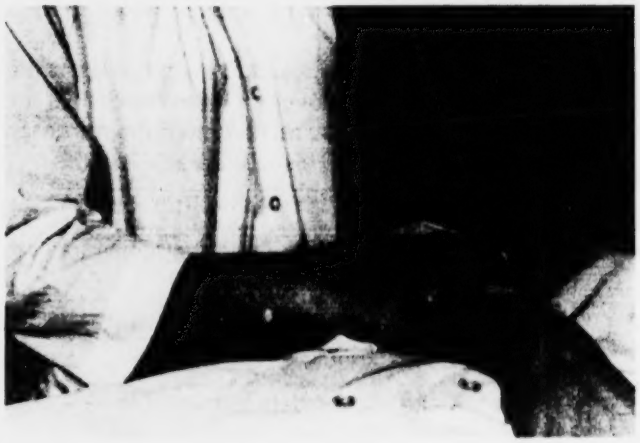
Functional Reading Skills
- Follow written instructions

Functional Math Skills
- Make measurements

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

FIGURE 1



4. Using the tips of your first two fingers (not your thumb), locate the radial pulse on the thumb side of the resident's wrist. (See Figure 2.)

FIGURE 2.

5. Count the resident's pulse for one full minute while exerting slight pressure over the radial artery.

6. While counting the resident's pulse, observe the resident's respirations for one full minute.

   NOTE: The resident must not know that you are counting his or her respirations. If the resident is aware that you are counting respirations, then the resident will change his or her breathing. This will make it impossible for you to get an accurate reading.

7. Record the pulse and the respiratory rate on paper immediately.

   EXAMPLE: P. 80 R. 12

8. Make the resident comfortable.

9. Wash your hands.

10. Chart the pulse and respiratory rates on the resident's care plan.

NOTE: If the resident's pulse falls below 60 beats per minute or goes above 100 beats per minute, report these readings to your supervisor. These readings may signify a disease process or a possible health problem.

OBJECTIVE 15

Take blood pressure.

INTRODUCTION

When you take a resident's blood pressure, you will be doing two things at the same time: you will be *listening* for the sound of the brachial artery, and you will be *watching* the indicator on the sphygmomanometer.

A blood pressure reading includes two types of pressure: the systolic pressure (top reading) and the diastolic pressure (bottom reading). These pressures are recorded in millimeters of mercury, written "mmHg."

EQUIPMENT AND SUPPLIES

- Sphygmomanometer (mercury or aneroid type)
- Stethoscope
- Paper and pen
- Cotton balls with antiseptic or antiseptic gauze wipes

PROCEDURE

Functional Reading Skills
- Follow written instructions

Functional Math Skills
- Make measurements

General Relating Skills
- Interact with clients/ customers/patients

Cognitive Activities Skills
- Transfer knowledge/ training to new situations

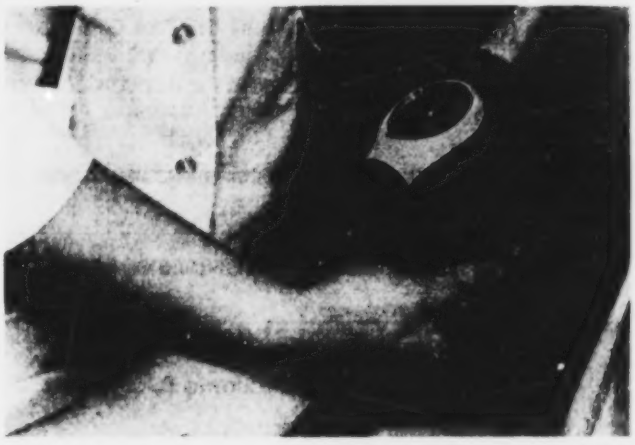
1. Wash your hands.
2. Explain the procedure to the resident.
3. Assist the resident to a sitting or lying position.
4. Position the resident's arm so that the arm is resting at the level of the heart with the palm facing upward.
5. Remove restrictive clothing from the arm or roll the sleeve up to the shoulder.
6. Determine that the blood pressure cuff is the appropriate size for the resident.

   NOTE: The cuff should be a little wide across the width of the arm above the elbow.

7. Position the cuff snugly around the resident's arm about one inch above the elbow, with the rubber bladder over the brachial artery. (See Figure 1.)

   NOTE: Most blood pressure cuffs have an arrow marked to identify the center of the bladder. Center this arrow along the inside of the elbow.

FIGURE 1



8. Clean the earpiece and the diaphragm of the stethoscope with antiseptic on cotton balls or with antiseptic gauze wipes. (See Figure 2.)

FIGURE 2

9. Place the earpiece of the stethoscope in your ears.

   NOTE: If using a bell-type stethoscope, make sure that it is *closed.*

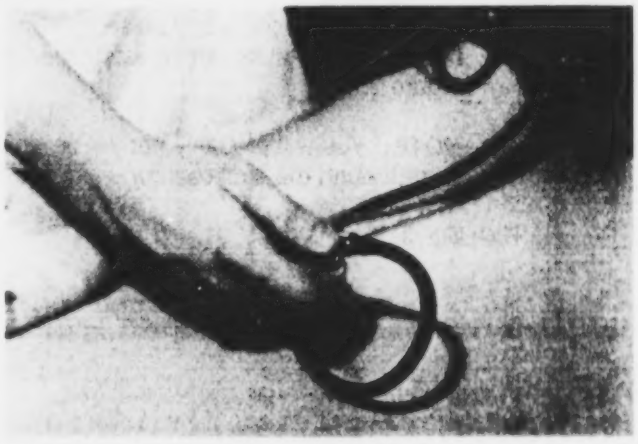
10. Locate the brachial artery pulse with your fingertips and place the diaphragm of the stethoscope over the pulse beat. (See Figure 3.)

    NOTE: You will probably not yet be able to hear the pulse beat through the stethoscope.

FIGURE 3

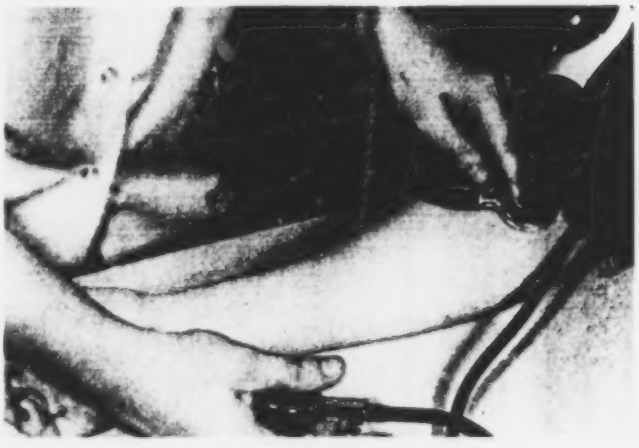
11. Tighten the screw on the rubber bulb of the sphygmomanometer. (See Figure 4.)

FIGURE 4



12. Inflate the cuff by squeezing the bulb repeatedly, listening for the pulse sounds to appear and then stop. Inflate the cuff about 20 mmHg higher after the pulse sounds stop. (See Figure 5.)

FIGURE 5



13. Open the thumb valve of the bulb slightly, gradually releasing the air in the cuff. (See Figure 6.)

FIGURE 6

14. Observe the manometer gauge at eye level (not the level of the meniscus) when the first strong pulse is heard. This is the systolic pressure.

    NOTE: Continue to listen while gradually releasing more air from the cuff and allowing the gauge to lower about 2-3 mmHg for each pulse beat.

15. Observe the manometer gauge at eye level when the last distinct loud sound is heard. This is the diastolic pressure.

    NOTE: Be sure to hold the stethoscope very still and do not move your hands. You might confuse the sounds of these movements with the pulse sounds.

16. Deflate the cuff completely by opening the bulb valve. The pressure will fall to zero.

17. Record the systolic and the diastolic pressures immediately.

    EXAMPLE: Blood pressure is written "120/80" and is read as "120 over 80."

18. Wait one minute with the cuff deflated, then repeat the procedure.

    NOTE: Blood pressure measurements can fluctuate slightly in a short period of time. Take the blood pressure again to check for accuracy.

19. Remove the cuff from the resident's arm and make the resident comfortable.

20. Clean the earpiece and the diaphragm of the stethoscope with antiseptic on cotton balls or with antiseptic gauze wipes.

21. Clean the area and return equipment and supplies to their proper storage.

22. Wash your hands.

23. Chart the blood pressure readings on the resident's care plan.

    NOTE: Report any changes from normal readings to your supervisor.

PRACTICAL TEST 1	OBTAIN VITAL SIGNS	3

JOB SHEET 1

Clean a mercury thermometer.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Obtained proper equipment and supplies.	____	____
2. Washed hands before starting the procedure.	____	____
3. Properly washed the thermometer.	____	____
4. Properly disinfected the thermometer (if applicable).	____	____
5. Cleaned the area and returned equipment and supplies to their proper storage.	____	____
6. Washed hands after finishing the procedure.	____	____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Thermometer is properly washed.	4	3	2	1
Thermometer is properly disinfected (if applicable).	4	3	2	1
Thermometer is stored in its case or in a container with antiseptic solution.	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 — Skilled — Can perform job with no additional training.
3 — Moderately skilled — Has performed job during training program; limited additional training may be required.
2 — Limited skill — Has performed job during training program; additional training is required to develop skill.
1 — Unskilled — Is familiar with process, but is unable to perform job.

JOB SHEET 2

Shake down a mercury thermometer.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Obtained proper equipment and supplies.	_____	_____
2. Washed hands before starting the procedure.	_____	_____
3. Held the thermometer by the stem between thumb and index finger.	_____	_____
4. Checked the thermometer for chips or cracks.	_____	_____
5. Checked the area for clearance.	_____	_____
6. Properly shook the thermometer until the mercury level was below 95.0°F.	_____	_____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Thermometer is not chipped or cracked as a result of shaking it down.	4	3	2	1
Mercury level after shaking is below 95.0°F.	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 —	Skilled — Can perform job with no additional training.
3 —	Moderately skilled — Has performed job during training program; limited additional training may be required.
2 —	Limited skill — Has performed job during training program; additional training is required to develop skill.
1 —	Unskilled — Is familiar with process, but is unable to perform job.

JOB SHEET 3

Take an oral temperature using a mercury thermometer.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Obtained proper equipment and supplies.	____	____
2. Washed hands before starting the procedure.	____	____
3. Made sure that the thermometer was properly cleaned.	____	____
4. Explained the procedure to the resident.	____	____
5. Assisted the resident to a sitting or lying position.	____	____
6. Shook the thermometer down before starting the procedure.	____	____
7. Rinsed the thermometer under cool water or placed a plastic cover over the thermometer.	____	____
8. Kept the thermometer in place for 8 minutes, while remaining with the resident.	____	____

	YES	NO
9. Properly removed the thermometer.	____	____
10. Recorded the temperature.	____	____
11. Made the resident comfortable after finishing the procedure.	____	____
12. Shook the thermometer down after finishing the procedure.	____	____
13. Properly cleaned the thermometer.	____	____
14. Cleaned the area and returned equipment and supplies to their proper storage.	____	____
15. Washed hands after finishing the procedure.	____	____
16. Correctly charted the temperature reading.	____	____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident's safety and comfort maintained throughout the procedure.	4	3	2	1
Temperature is properly charted.	4	3	2	1
Thermometer is properly cleaned, shaken down and stored after the procedure is finished.	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 — Skilled — Can perform job with no additional training.
3 — Moderately skilled — Has performed job during training program; limited additional training may be required.
2 — Limited skill — Has performed job during training program; additional training is required to develop skill.
1 — Unskilled — Is familiar with process, but is unable to perform job.

PRACTICAL TEST 4	OBTAIN VITAL SIGNS 3

JOB SHEET 4

Take a radial pulse rate and respiratory rate.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Obtained proper equipment and supplies.	_____	_____
2. Washed hands before starting the procedure.	_____	_____
3. Explained the procedure to the resident.	_____	_____
4. Placed the resident's arm in a comfortable position at heart level.	_____	_____
5. Correctly located the radial pulse.	_____	_____
6. Counted the resident's pulse for one full minute.	_____	_____
7. Observed the resident's respirations while counting the pulse.	_____	_____
8. Recorded the pulse and respiratory rates.	_____	_____
9. Made the resident comfortable after finishing the procedure.	_____	_____

	YES	NO
10. Cleaned the area and returned equipment and supplies to their proper storage.	____	____
11. Washed hands after finishing the procedure.	____	____
12. Correctly charted the pulse and respiratory rates.	____	____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident's safety and comfort maintained throughout the procedure.	4	3	2	1
Pulse rate is properly charted.	4	3	2	1
Respiratory rate is properly charted.	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 —	Skilled — Can perform job with no additional training.
3 —	Moderately skilled — Has performed job during training program; limited additional training may be required.
2 —	Limited skill — Has performed job during training program; additional training is required to develop skill.
1 —	Unskilled — Is familiar with process, but is unable to perform job.

JOB SHEET 5

Take blood pressure.

STUDENT'S NAME _____ DATE _____

EVALUATOR'S NAME _____ ATTEMPT NO. _____

INSTRUCTIONS

When you are ready to perform this task, ask your instructor to observe the procedure and complete this form. All items listed under "Process Evaluation" must receive a "Yes" for you to receive an acceptable performance evaluation.

PROCESS EVALUATION

Evaluator Note: Place a check mark in the "Yes" or "No" blanks to designate whether or not the student has satisfactorily achieved each step in this procedure. If the student is unable to achieve this competency, have the student review the materials and try again.

The student	YES	NO
1. Obtained proper equipment and supplies.	_____	_____
2. Washed hands before starting the procedure.	_____	_____
3. Explained the procedure to the resident.	_____	_____
4. Assisted the resident to a sitting or lying position.	_____	_____
5. Properly positioned the resident's arm.	_____	_____
6. Properly handled restrictive clothing.	_____	_____
7. Used a cuff of the appropriate size.	_____	_____
8. Correctly positioned the cuff around the resident's arm.	_____	_____
9. Properly cleaned the earpiece and diaphragm of the stethoscope before starting the procedure.	_____	_____
10. Correctly used the sphygmomanometer.	_____	_____

	YES	NO
11. Correctly recorded the systolic and diastolic pressures.	____	____
12. Repeated the procedure for accuracy.	____	____
13. Made the resident comfortable after finishing the procedure.	____	____
14. Properly cleaned the earpiece and diaphragm of the stethoscope after finishing the procedure.	____	____
15. Cleaned the area and returned equipment and supplies to their proper storage.	____	____
16. Washed hands after finishing the procedure.	____	____
17. Correctly charted the blood pressure readings.	____	____

EVALUATOR'S COMMENTS

_____

_____

PRODUCT EVALUATION

Evaluator Note: Rate the student on the following criteria by circling the appropriate numbers. Each criterion must receive a rating of "3" or higher to demonstrate student mastery. (See performance evaluation key.) A student who is unable to demonstrate mastery should review the materials and submit another product for evaluation.

Criteria				
Resident's safety and comfort maintained throughout the procedure.	4	3	2	1
Blood pressure is properly charted.	4	3	2	1
Stethoscope is properly cleaned and stored for the next use.	4	3	2	1
Sphygmomanometer is ready for the next use.	4	3	2	1

EVALUATOR'S COMMENTS

_____

_____

_____

AVERAGE RATING

Evaluator Note: To obtain an average rating for the competency profile, total the designated points in "Product Evaluation" and divide by the total number of criteria. Circle the rating on the "Performance Evaluation Key" below.

PERFORMANCE EVALUATION KEY

4 — Skilled — Can perform job with no additional training.
3 — Moderately skilled — Has performed job during training program; limited additional training may be required.
2 — Limited skill — Has performed job during training program; additional training is required to develop skill.
1 — Unskilled — Is familiar with process, but is unable to perform job.

OBTAIN VITAL SIGNS

NAME _____ SCORE _____

OBJECTIVE 1

Match terms associated with vital signs to their correct definition. Write the correct letter in each blank.

_____1. Relating to the wrist	a. Aneroid
_____2. A dial-type of pressure gauge without mercury, used in some sphygmomanometers	b. Axillary
_____3. A temperature scale having 32 degrees as the freezing point and 212 degrees as the boiling point	c. Blood pressure
_____4. The lines on the scale of a thermometer, at intervals of two-tenths of a degree on a Fahrenheit thermometer and one-tenth of a degree on a Centigrade (Celsius) thermometer	d. Calibration
_____5. A temperature scale having zero degrees as the freezing point and 100 degrees as the boiling point	e. Centigrade (Celsius)
_____6. Relating to the armpit; a temperature is taken by placing the thermometer snugly in the armpit	f. Diastolic pressure
_____7. Relating to the mouth; a temperature is taken by placing the thermometer in the mouth and under the tongue	g. Fahrenheit
	h. Oral
	i. Pulse
	j. Radial
	k. Rectal
	l. Respiration
	m. Sphygmomanometer
	n. Systolic pressure

_____8. The force of blood pushing against the walls of blood vessels, recorded in millimeters of mercury (mmHg); the reading includes the systolic pressure (top number) and the diastolic pressure (bottom number)

_____9. The amount of pressure against the walls of blood vessels when the heart relaxes between each beat; recorded as the bottom number of the blood pressure reading

_____10. A measurement of how fast the heart is beating

_____11. The act of breathing in (inspiration) and breathing out (expiration)

_____12. Relating to the rectum; a temperature is taken by inserting the thermometer gently into the anus

_____13. An instrument used for measuring blood pressure

_____14. The amount of pressure against the walls of blood vessels when the heart is contracting or forcing the blood through the vessels; recorded as the top number of the blood pressure reading

OBJECTIVE 2

Write the symbols for charting vital signs. Write the correct symbol in each blank.

1. Blood pressure = _____

2. Centigrade/Celsius = _____

3. Degree = _____

4. Fahrenheit = _____

5. Pulse = _____

6. Respiration = _____

7. Temperature = _____

OBJECTIVE 3 **State guidelines for reading a mercury thermometer.**

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

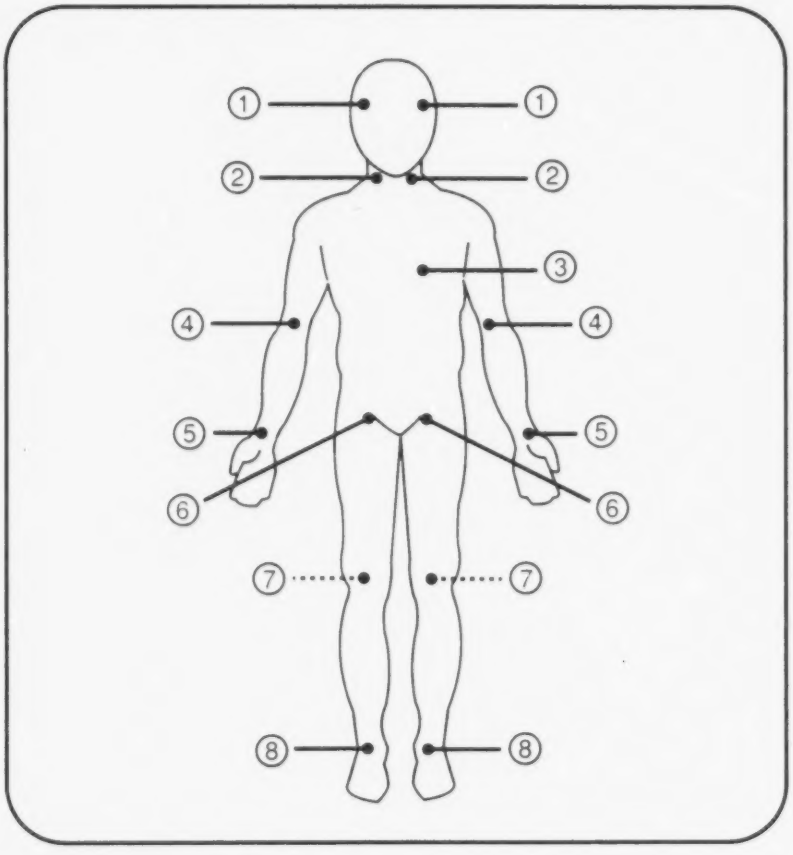
OBJECTIVE 4 **State two items that the pulse rate identifies.**

1. _____

2. _____

OBJECTIVE 5

Locate the pulse points on the human body. Write the name of each pulse point in the correct blank.



1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

OBJECTIVE 6	**Explain blood pressure.** Include as many main points as possible.	
	_____	
	_____	
	_____	
	_____	
	_____	
	_____	
NOTICE	The following objectives are not a part of the Written Test.	
OBJECTIVE 7	**Chart vital signs.**	SCORE _____
OBJECTIVE 8	**Read a mercury thermometer.**	SCORE _____
OBJECTIVE 9	**Convert Fahrenheit and Centigrade (Celsius) temperature readings.**	SCORE _____
OBJECTIVE 10	**Read sphygmomanometer gauges.**	SCORE _____
OBJECTIVE 11	**Clean a mercury thermometer.**	RATING _____
OBJECTIVE 12	**Shake down a mercury thermometer.**	RATING _____
OBJECTIVE 13	**Take an oral temperature using a mercury thermometer.**	RATING _____
OBJECTIVE 14	**Take a radial pulse rate and respiratory rate.**	RATING _____
OBJECTIVE 15	**Take blood pressure.**	RATING _____

OBJECTIVE 1

1. j
2. a
3. g
4. d
5. e
6. b
7. h
8. c
9. f
10. i
11. l
12. k
13. m
14. n

OBJECTIVE 2

1. B/P
2. C
3. °
4. F
5. P.
6. R.
7. T.

OBJECTIVE 3

In any order:

- Hold the thermometer by the stem at eye level.
- Turn the thermometer slowly between your thumb and index finger until you can see the column of mercury clearly.
- When reading a Fahrenheit thermometer, count two-tenths of a degree (0.2) between each calibration.
- When reading a Centigrade (Celsius) thermometer, count one-tenth of a degree (0.1) between each calibration.

OBJECTIVE 4

In any order:

- The rate — how many times the heart beats per minute
- The rhythm — how regular or irregular the heart beats

OBJECTIVE 5

1. Temporal pulse
2. Carotid pulse
3. Apical pulse
4. Brachial pulse
5. Radial pulse
6. Femoral pulse
7. Popliteal pulse
8. Pedal pulse or dorsalis pulse

OBJECTIVE 6

Blood pressure is the force of blood pushing against the walls of blood vessels. When you take a resident's blood pressure, you are measuring the force of the blood flowing through the arteries. The heart, by pumping, is constantly forcing the blood to circulate throughout the body. The pressure in the arteries depends on the rate of the heartbeat and on how easily the blood flows through the blood vessels. Blood pressure is at its highest (systolic pressure) when the heart is contracting or forcing the blood through the vessels; it is at its lowest (diastolic pressure) when the heart relaxes between each beat.

OBJECTIVE SHEET

DISCUSS LEGAL ISSUES AND RESIDENTS' RIGHTS 4

INTRODUCTION

The legal responsibilities of the MAT have been defined broadly by the Oklahoma Statutes, such as through the Residential Care Act and the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act, and in more detail by the State Department of Health in its *Standards and Regulations for Licensure*. Knowing your legal responsibilities will benefit you, your employer, and the residents of your facility. There is no absolute protection against being named in a lawsuit; your best protection is *prevention*.

UNIT OBJECTIVE

After completing this unit, you will know your legal responsibilities with respect to some common legal issues that affect the MAT. You will demonstrate these competencies by completing the Written Test with a minimum of eighty-five percent (85%) accuracy.

PREREQUISITES

Before studying this unit, you should have successfully completed the *Medication Administration Technician* training program.

SPECIFIC OBJECTIVES

After completing this unit, you should be able to

1. List standards of care guiding the actions of the MAT.
2. Select from a list resident rights and responsibilities adopted by the Oklahoma State Department of Health.
3. Select from a list possible penalties for the MAT or the MAT's employer for violating provisions of the Residential Care Act, the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act, or any rule, regulation, or order issued pursuant to their provisions.
4. Distinguish among types of wrongful actions for which the MAT may be held liable to another person.
5. Select from a list legal requirements for reporting abuse or neglect of a resident.
6. List types of information requiring confidentiality.
7. State guidelines for maintaining the confidentiality of privileged information.

8. Explain the legal significance of a controlled drug.

9. State general guidelines for meeting the legal responsibilities of the MAT.

SUGGESTED ACTIVITIES	DISCUSS LEGAL ISSUES AND RESIDENTS' RIGHTS 4
PREPARATION	• Order additional materials to supplement this unit. • Review the unit and plan your presentation: — Estimate the amount of material that can be covered in each class session. — Identify objectives that you can supplement with other resources. — Invite guest speakers in advance. • Design transparencies and handouts to reinforce the objectives in each unit, to provide additional information, or to facilitate in-class activities.
DELIVERY	**Objective 1** • Give examples of each standard. • Identify the *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma* and the *Standards and Regulations for Licensure of Group Homes in Oklahoma.* This document is available from the following address: Oklahoma State Department of Health Special Health Services P.O. Box 53551 Oklahoma City, OK 73152 • Create scenarios and ask students what a "reasonable person" would do. **Objective 2** • Discuss each of the residents' rights. Explain that these are the *minimum* rights identified in the *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma* and in the *Standards and Regulations for Licensure of Group Homes in Oklahoma.* • Create and discuss scenarios involving the violation of these rights.

Objective 3

- Explain how these penalties could affect (1) the MAT, and (2) the MAT's employer.

Objective 4

- Give examples of each action.

Objective 5

- Emphasize the point that *it is a crime* to fail to report a case of abuse or neglect.
- Outline the steps for reporting cases of abuse or neglect. Give the appropriate telephone numbers and addresses.

Objective 6 and 7

- Discuss problems that could develop if the MAT is not careful with privileged information. Create and discuss scenarios where privileged information (1) is improperly discussed, and (2) is properly kept confidential.
- Discuss how confidentiality protects the resident, the MAT, and the MAT's employer.
- State that confidentiality is also a *professional responsibility* of the MAT.
- Give examples of each guideline.

Objective 8

- Distribute current classifications of controlled drugs.
- Give an example of each statement about the legal significance of controlled drugs.
- Ask students to explain the procedures regarding controlled drugs in effect at their facility.

Objective 9

- Discuss the legal significance of each guideline.
- Illustrate the importance of written documentation.

EVALUATION

Written Test

- Give the Written Test soon after presenting the unit.
- Remind students throughout your presentation that the questions and required performance on each Written Test match the Specific Objectives stated at the beginning of the unit and the objectives discussed in the unit.
- Review individual and group performance in order to evaluate teaching methods. Adjust your approach as needed.

UNIT REFERENCES

- Curriculum and Instructional Materials Center, *Medication Administration Technician*, Oklahoma Department of Vocational and Technical Education, Stillwater, Oklahoma, 1989.
- East Central University, Division of Adult and Continuing Education, *MAT Update*, East Central University, Ada, Oklahoma.
- Oklahoma State Department of Health, Special Health Services, *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma*, Oklahoma City, Oklahoma, 1989.
- Oklahoma State Department of Health, Licensure and Certification Division, *Standards and Regulations for Licensure of Group Homes in Oklahoma*, Oklahoma City, Oklahoma, 1988.

INFORMATION SHEET	DISCUSS LEGAL ISSUES AND RESIDENTS' RIGHTS 4

OBJECTIVE 1 **List standards of care guiding the actions of the MAT.**

- Statutes

  EXAMPLE: The Residential Care Act (Sections 1-820 through 1-840 of Title 63 of the Oklahoma Statutes); the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act

- Regulations

  EXAMPLE: *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma*, adopted by the Oklahoma State Department of Health, January 26, 1989; *Standards and Regulations for Licensure of Group Homes in Oklahoma*, adopted June 23, 1988

- Institutional standards of care

  EXAMPLE: Job descriptions, job training materials, institutional guidelines

- Actions that a reasonable person would do or not do if in the same position

OBJECTIVE 2 **Select from a list resident rights and responsibilities adopted by the Oklahoma State Department of Health.**

> The following information is adapted from the *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma* and the *Standards and Regulations for Licensure of Group Homes in Oklahoma* by the Oklahoma State Department of Health.

- Exercise civil and religious liberties, including the right to independent personal decisions and knowledge of available choices

- Communicate and consult privately with a physician, attorney, or any other person

- Send and promptly receive, unopened, personal mail

- Present grievances on behalf of himself/herself or others to the residential care home's/group home's staff or administrator, to governmental officials, or to any other person without fear of reprisal

  NOTE: Each resident also has the right to join with other residents or individuals within or outside of the facility to work for improvements in resident care.

- Manage personal financial affairs, unless delegated in writing

- Receive an accounting at least quarterly of any personal financial transactions undertaken in his/her behalf by the residential care home/group home during any period of time such responsibilities have been delegated to the [residential care/group] home

- Receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community

- Be fully informed by his/her attending physician of his/her medical condition and proposed treatment in terms and language that the resident can understand, unless medically inappropriate

- Refuse medication and treatment after being fully informed of and understanding the consequences of such actions

- Receive respect and privacy in his/her medical care program

  NOTE: Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential.

- Retain and use personal clothing and possessions, unless medically inappropriate

  NOTE: The resident also has the *right to security* in the storage and use of such clothing and possessions.

- Receive courteous and respectful care and treatment

- Be free from mental and physical abuse, and from physical and chemical restraints as provided by the program certification standards

- Receive a statement of the facility's regulations and an explanation of the resident's responsibility to obey

- Not to be required to perform services for a residential care/group home

  NOTE: "Services for a residential care/group home" does not refer to the resident's regular participation in shared household tasks when these tasks are included as part of a training, habilitation, or rehabilitation plan for the resident pursuant to the program certification requirements for the residential care/group home and are performed as a part of normal shared household tasks.

- Have privacy for spousal visits

  NOTE: Every resident may share a room with his/her spouse, if the spouse is residing in the same residential care home.

- Have next of kin, or representative, notified of the resident's death or imminent death (when a physician indicates that it is appropriate)

OBJECTIVE 3

Select from a list possible penalties for the MAT or the MAT's employer for violating provisions of the Residential Care Act, the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act, or any rule, regulation, or order issued pursuant to their provisions.

- Any person who violates any of the provisions of [either Act], upon conviction, is guilty of a *misdemeanor.*

  EXAMPLE: Violating any of the rights of a resident, as outlined in the *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma* or the *Standards and Regulations for Licensure of Group Homes in Oklahoma*

- Any person determined by the State Department of Health to have violated any provisions of [either Act] or any rule, regulation, or order issued pursuant to the provisions of [either Act] may be liable for a civil penalty of *not more than one hundred dollars ($100.00) for each day* that the violation continues.

  NOTE: The maximum civil penalty is ten thousand dollars ($10,000.00) for any related series of violations.

- A violation by any person of a provision of [either Act] or any rule, regulation, or order issued pursuant to their provisions, *may be prosecuted.*

OBJECTIVE 4

Distinguish among types of wrongful actions for which the MAT may be held liable to another person.

In addition to the possible penalties for violating provisions of the Residential Care Act or the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act, you can be held liable to another person for any of the following wrongful actions.

- **Assault** — Actions intended to make the resident aware of an immediate harmful or offensive touching

  EXAMPLE: Threatening a resident

- **Battery** — Actions that result in a harmful or offensive touching or other physical violence or constraint of the resident without the resident's permission

  NOTE: The resident need not be *aware* of what is happening.

- **False imprisonment** — An act or omission with the intent to confine someone and that results in the actual confinement of a resident, or either awareness of the confinement or injury from it

- **Intentionally inflicting emotional distress** — An extreme and outrageous act intended to cause severe emotional distress or recklessness with regard to such injuries resulting in severe emotional distress

- **Negligence (neglect)** — An unintentional wrong in which a person fails to act in a reasonable and careful manner — with respect to a duty or obligation recognized by law requiring the person to conform to a certain standard of care for the protection of others against unreasonable harm — and, as a result, causes harm to another person or to that person's property

  EXAMPLE: Failing to ensure a resident's informed consent; failing to report a change in a resident's vital signs; failing to report the negligence of another staff member that you witnessed

OBJECTIVE 5 **Select from a list legal requirements for reporting abuse or neglect of a resident.**

- The residential care/group home must have a written policy statement that expressly prohibits the abuse or neglect of the individuals it serves.
- Any person who becomes aware of abuse or neglect of a resident must report the matter immediately to the State Department of Health or Department of Human Services.
- Any person who knowingly and willfully fails to promptly report any abuse or neglect, upon conviction, is guilty of a misdemeanor.

OBJECTIVE 6 **List types of information requiring confidentiality.**

- Any information about a resident's condition or treatment
- All of a resident's records
- Personal information about the resident, such as economic status, family problems, telephone messages

OBJECTIVE 7 **State guidelines for maintaining the confidentiality of privileged information.**

- Keep resident records in a lockable container or in a specific lockable area.
- Allow only those persons authorized by the residential care home to have access to resident records.

- Keep the contents of all records confidential.

- Be sensitive to each resident's need for *privacy* and *dignity*.

- If specific information requiring confidentiality must be shared with anyone, follow the appropriate guidelines for obtaining oral or written consent in advance.

  NOTE: There are exceptions to the need for advance consent: (1) you are required *by law* to report suspected cases of abuse or neglect of a resident; and (2) you must report communicable diseases to the appropriate officials. *Ask your supervisor about procedures relating to these exceptions.*

OBJECTIVE 8 **Explain the legal significance of a controlled drug.**

NOTE: Federal and state laws classify controlled substances into lists called "Schedules." Drugs listed within a schedule have a similar potential for abuse. The drugs listed in each schedule may change as new drugs are added and old drugs are reclassified.

- A controlled drug may or may not be currently accepted for medical use in the United States.

- A controlled drug has the *potential for abuse* and may result in *physical or psychologic dependence if abused*.

- A controlled drug may have specific requirements for *storage*.

  EXAMPLE: The *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma* and the *Standards and Regulations for Licensure of Group Homes in Oklahoma* require that drugs in Schedule II be kept in a separate locked box within the locked medication area.

- A controlled drug requires *limited access* to the drug.

  EXAMPLE: Your employer will have specific policies regarding who has access to these drugs.

- A controlled drug may have specific requirements for *administering* the drug.

- A controlled drug may have specific requirements for *documenting* the administration of the drug.

  EXAMPLE: The *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma*, and those for Group Homes, require that an individual inventory record and documentation for accountability be maintained for each Schedule II drug prescribed for each resident.

- A controlled drug may have specific requirements for *disposing* of the drug in case the drug becomes contaminated or is not administered.

OBJECTIVE 9

State general guidelines for meeting the legal responsibilities of the MAT.

- Follow regulations developed by the State Department of Health when making decisions about how to deal with the residents at your facility.
- Review the standards of care and all guidelines set by your facility.
- Read and follow your job description.
- Read and follow your training manual.
- Document everything *in writing*.

  EXAMPLE: Incidents, accidents, medication administration, treatments, progress notes, consent forms from residents

- Follow all guidelines for documenting the administration of medications.
- Know the procedures for storing, administering, documenting, and disposing the *controlled drugs* at your facility.
- Get written consent from the resident or the resident's representative regarding the sharing of privileged information.
- Report any incidents of abuse or neglect of a resident *immediately*.

WRITTEN TEST

DISCUSS LEGAL ISSUES AND RESIDENTS' RIGHTS 4

NAME _____ SCORE _____

OBJECTIVE 1

List standards of care guiding the actions of the MAT.

1. _____
2. _____
3. _____
4. _____

OBJECTIVE 2

Select from a list resident rights and responsibilities adopted by the Oklahoma State Department of Health. Write an "X" in the blank beside each resident right.

_____1. Communicate and consult with a physician, attorney, or other person approved by the residential care home

_____2. Send and promptly receive, unopened, personal mail

_____3. Present grievances on behalf of himself/herself only

_____4. Manage personal financial affairs, unless delegated in writing

_____5. Receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community

_____6. Be fully informed by his/her attending physician of his/her medical condition and proposed treatment in terms and language that the resident can understand, unless medically inappropriate

_____7. Accept any medication and treatment prescribed by a competent physician

_____8. Receive respect and privacy in his/her medical care program

_____9. Retain and use personal clothing and possessions, unless medically inappropriate

_____10. Receive courteous and respectful care and treatment

_____11. Be free from mental and physical abuse, and from physical and chemical restraints as provided by the program certification standards

_____12. Perform services for the residential care/group home

_____13. Have privacy for spousal visits

OBJECTIVE 3

Select from a list possible penalties for the MAT or the MAT's employer for violating provisions of the Residential Care Act, the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act, or any rule, regulation, or order issued pursuant to their provisions. Write an "X" in the blank beside each possible penalty.

_____1. Any person who violates any of the provisions of [either Act], upon conviction, is guilty of a *misdemeanor*.

_____2. Any person who violates any of the provisions of [either Act], upon conviction, is guilty of a *felony*.

_____3. Any person determined by the State Department of Health to have violated any provisions of [either Act] or any rule, regulation, or order issued pursuant to the provisions of [either Act] may be liable for a civil penalty of *not more than one hundred dollars ($100.00) for each day* that the violation continues.

_____4. A violation by any person of a provision of [either Act] or any rule, regulation, or order issued pursuant to their provisions, *may be prosecuted*.

OBJECTIVE 4

Distinguish among types of wrongful actions for which the MAT may be held liable to another person. Write the letter of the correct term in each blank.

_____1. Actions that result in a harmful or offensive touching or other physical violence or constraint of the resident without the resident's permission

_____2. An extreme and outrageous act intended to cause severe emotional distress or recklessness with regard to such injuries resulting in severe emotional distress

_____3. An act or omission with the intent to confine someone and that results in the actual confinement of a resident, or either awareness of the confinement or injury from it

_____4. An unintentional wrong in which a person fails to act in a reasonable and careful manner — with respect to a duty or obligation recognized by law requiring the person to conform to a certain standard of care for the protection of others against unreasonable harm — and, as a result, causes harm to another person or to that person's property

_____5. Actions intended to make the resident aware of an immediate harmful or offensive touching

a. Assault

b. Battery

c. False imprisonment

d. Intentionally inflicting emotional distress

e. Negligence (neglect)

OBJECTIVE 5

Select from a list legal requirements for reporting abuse or neglect of a resident. Write an "X" in the blank beside each legal requirement.

_____1. The residential care/group home must have a written policy statement that expressly prohibits the abuse or neglect of the individuals it serves.

_____2. Any person who becomes aware of abuse or neglect of a resident must report the matter immediately to the police.

_____3. Any person who knowingly and willfully fails to promptly report any abuse or neglect, upon conviction, is guilty of a misdemeanor.

OBJECTIVE 6

List types of information requiring confidentiality.

1. _____

2. _____

3. _____

OBJECTIVE 7

State guidelines for maintaining the confidentiality of privileged information. Give three (3) guidelines.

1. _____

_____

2. _____

_____

3. _____

_____

OBJECTIVE 8

Explain the legal significance of a controlled drug. Include as many main points as possible.

OBJECTIVE 9

State general guidelines for meeting the legal responsibilities of the MAT.

1. Regulations developed by the State Department of Health —

2. Standards of care —

3. Job description —

4. Training manual —

5. Writing —

6. Controlled drugs — _____

_____

7. Abuse or neglect — _____

_____

WRITTEN TEST ANSWERS	DISCUSS LEGAL ISSUES AND RESIDENTS' RIGHTS 4
OBJECTIVE 1	In any order: 1. Statutes 2. Regulations 3. Institutional standards of care 4. Actions that a reasonable person would do or not do if in the same position
OBJECTIVE 2	2, 4, 5, 6, 8, 9, 10, 11, 13
OBJECTIVE 3	1, 3, 4
OBJECTIVE 4	1. b 2. d 3. c 4. e 5. a
OBJECTIVE 5	1, 3
OBJECTIVE 6	In any order: 1. Any information about a resident's condition or treatment 2. All of a resident's records 3. Personal information about the resident, such as economic status, family problems, telephone messages
OBJECTIVE 7	Any three (3) of the following: • Keep resident records in a lockable container or in a specific lockable area. • Allow only those persons authorized by the residential care home to have access to resident records. • Keep the contents of all records confidential.

- Be sensitive to each resident's need for *privacy* and *dignity*.
- If specific information requiring confidentiality must be shared with anyone, follow the appropriate guidelines for obtaining oral or written consent in advance.

OBJECTIVE 8

Check for the presence of the following points:

- A controlled drug may or may not be currently accepted for medical use in the United States.
- A controlled drug has the *potential for abuse* and may result in *physical or psychologic dependence if abused*.
- A controlled drug may have specific requirements for *storage*.
- A controlled drug requires *limited access* to the drug.
- A controlled drug may have specific requirements for *administering* the drug.
- A controlled drug may have specific requirements for *documenting* the administration of the drug.
- A controlled drug may have specific requirements for *disposing* of the drug in case the drug becomes contaminated or is not administered.

OBJECTIVE 9

1. Follow regulations developed by the State Department of Health when making decisions about how to deal with the residents at your facility.
2. Review the standards of care and all guidelines set by your facility.
3. Read and follow your job description.
4. Read and follow your training manual.
5. Document everything *in writing*.
6. Know the procedures for storing, administering, documenting, and disposing the *controlled drugs* at your facility.
7. Report any incidents of abuse or neglect of a resident *immediately*.

OBJECTIVE SHEET

PREPARE FOR MEDICAL EMERGENCIES 5

INTRODUCTION

As a MAT, you may be the person closest to the resident to see any side effects or drug interactions. Some interactions can have very mild effects, while others can be life-threatening. For this reason, you should be familiar with some of the medical emergencies that can happen, as well as the correct steps to take. However, it is not possible for the MAT to recognize all of the possible drug-drug and drug-food interactions. A good reference should also be available.

UNIT OBJECTIVE

After completing this unit, you will be able to describe some common medical emergencies and the correct response to each. You will demonstrate these competencies by completing the Written Test with a minimum of eighty-five percent (85%) accuracy.

PREREQUISITES

Before studying this unit, you should have successfully completed the *Medication Administration Technician* training program.

SPECIFIC OBJECTIVES

After completing this unit, you should be able to

1. Match terms associated with medical emergencies to their correct definition.
2. List possible results of drug-drug and drug-food interactions.
3. List information to be posted concerning medical emergencies.
4. Select from a list guidelines for preparing for medical emergencies.
5. Distinguish among types of medical emergencies according to their signs, symptoms, and treatment.

PREPARATION

- Order additional materials to supplement this unit.
- Review the unit and plan your presentation:
  - — Estimate the amount of material that can be covered in each class session.
  - — Identify objectives that you can supplement with other resources.
  - — Invite guest speakers in advance.
- Design transparencies and handouts to reinforce the objectives in each unit, to provide additional information, or to facilitate in-class activities.

DELIVERY

Objective 1

- Give examples of *allergens*.

Objective 2

- Give other examples of each possible result.

Objective 3

- Ask students to identify the location(s) in their facility where this information is posted.

Objective 4

- Demonstrate how to use drug reference books such as the *Physician's Desk Reference* and others.
- Review the importance of proper charting (from Unit 6).

Objective 5

- Discuss the signs, symptoms, and treatments.

EVALUATION

Written Test

- Give the Written Test soon after presenting the unit.

- Remind students throughout your presentation that the questions and required performance on each Written Test match the Specific Objectives stated in the beginning of the unit and the objectives discussed in the unit.

- Review individual and group performance in order to evaluate teaching methods. Adjust your approach as needed.

UNIT REFERENCES

- Curriculum and Instructional Materials Center. *Medication Administration Technician*. Oklahoma Department of Vocational and Technical Education. Stillwater, Oklahoma. 1989.

- East Central University, Division of Adult and Continuing Education. *MAT Update*. East Central University, Ada, Oklahoma.

OBJECTIVE 1

Match terms associated with medical emergencies to their correct definition.

- **Allergen** — A substance that causes an allergy

  EXAMPLE: Common allergens are environmental, such as dust, mold, and pollen. Other allergens can be drugs, foods, chemicals, and insect bites.

- **Allergy** — A personal, physical reaction to a substance, a situation, or a physical state (such as to heat or cold)

- **Anaphylaxis** — A severe and possibly life-threatening allergic reaction to a foreign protein or drug after one or more exposures

  EXAMPLE: Penicillin is a very common cause of anaphylaxis.

- **Drug hypersensitivity** — An allergic reaction to a drug after exposure by any route at any time

- **Urticaria (hives)** — A temporary skin reaction, which may reappear, usually limited to the individual and which takes the form of large or small lesions on the body

OBJECTIVE 2

List possible results of drug-drug and drug-food interactions.

- Drug is not adequately absorbed into the bloodstream

- Drug is not activated

  EXAMPLE: Tetracycline and calcium

- Potential side effects

  EXAMPLE: Drowsiness

OBJECTIVE 3

List information to be posted concerning medical emergencies.

- Supervisor's name and telephone number
- RN consultant's name and telephone number (if appropriate)
- Physician's name and telephone number (where appropriate)
- Poison Control Center telephone number
- Fire department and ambulance service telephone numbers
- Area hospitals' telephone numbers
- Law enforcement agency telephone numbers

  EXAMPLE: Police department, sheriff's office

NOTE: These numbers should be posted so that they are visible from the outside of the building. In addition to the above names and telephone numbers, you should know others that may apply to your facility.

OBJECTIVE 4

Select from a list guidelines for preparing for medical emergencies.

- Know the location(s) of emergency telephone numbers posted in your facility.
- Watch for the planned reaction and for possible side effects of medication administered to individual residents.

  NOTE: The MAT may be the person closest to the resident to see any side effects or drug interactions.

- Report and record signs or symptoms of possible interactions.

  NOTE: Know to whom you should report any suspected interactions. Record the signs or symptoms that you observe; do not record your interpretation of these signs or symptoms.

- Know the proper procedures to follow and the persons to contact if a resident has refused medication, or if a dose has been missed.

- Know how to respond to possible emergency situations with individual residents before they happen.

  EXAMPLE: You can anticipate some emergencies if you know enough about individual residents. Procedures should be in place in advance for handling residents with a history of seizures, residents with diabetes or heart disease, or other residents with known medical histories.

OBJECTIVE 5

Distinguish among types of medical emergencies according to their signs, symptoms, and treatment.

Type of Emergency	*Signs and Symptoms*	*Treatment*
1. Allergies	• Nasal congestion • Tearing • Sneezing • Wheezing • Coughing • Itchy rash (sometimes)	• Chart any allergic response on the appropriate form(s). • Call your supervisor. • If the resident has difficulty breathing, call the resident's physician *immediately* and monitor the resident closely. (Emergency personnel may have to be called and CPR started, if necessary.) • Make sure that the resident's physician is called before a repeated dose of the possible allergen is administered.

Type of Emergency	*Signs and Symptoms*	*Treatment*
2. Urticaria (hives)	Raised and distinct marks on the skin, with a rounded or flat top, with surrounding redness	• Call the resident's physician about the need to start any treatment. • Document the signs, symptoms, and treatment on the resident's chart.
3. Anaphylaxis	• Sudden physical distress (usually within 45 minutes of exposure to an allergen) • Feeling of coming doom; fright • Weakness • Sweating • Shortness of breath • Hives (possibly)	• Make sure that the resident is transported to a hospital emergency room *as soon as possible*. **♦ WARNING ♦** **Anaphylaxis is always an emergency. A resident having an anaphylactic reaction will rapidly go into shock, and sometimes cardiac arrest.**

Type of Emergency	*Signs and Symptoms*	*Treatment*
3. Anaphylaxis (continued)		• Call your supervisor. **NOTE:** Your facility may have emergency medications available—such as epinephrine—that must be injected by your supervisor in cases of severe allergic reaction. • Call the resident's physician. • Monitor the resident's vital signs. • Start CPR, if necessary and if you are qualified to do so. • Document the signs, symptoms, and treatment on the resident's chart.

Type of Emergency	*Signs and Symptoms*	*Treatment*
4. Drug hypersensitivity	Signs and symptoms vary from mild, local symptoms such as redness, swelling, and itching to severe disorders such as asthma, anemia, or anaphylaxis	• Be aware of a resident's history of drug, food, and environmental allergies before giving medications. • Watch for the planned reaction and for possible side effects of medication administered to individual residents. **NOTE:** The MAT may be the person closest to the resident to see any side effects or drug interactions. • Educate the resident to recognize and immediately report any signs of allergic reaction. **CAUTION** Early recognition could make the difference between a mild rash and sometimes deadly anaphylaxis.

NAME _____ SCORE _____

OBJECTIVE 1

Match terms associated with medical emergencies to their correct definition. Write the correct letter in each blank.

_____1. A personal, physical reaction to a substance, a situation, or a physical state (such as to heat or cold)

_____2. An allergic reaction to a drug after exposure by any route at any time

_____3. A temporary skin reaction, which may reappear, usually limited to the individual and which takes the form of large or small lesions on the body

_____4. A substance that causes an allergy

_____5. A severe and possibly life-threatening allergic reaction to a foreign protein or drug after one or more exposures

a. Allergen

b. Allergy

c. Anaphylaxis

d. Drug hypersensitivity

e. Urticaria (hives)

OBJECTIVE 2

List possible results of drug-drug and drug-food interactions.

1. _____

2. _____

3. _____

OBJECTIVE 3

List information to be posted concerning medical emergencies. List four (4) items that should be posted at your facility.

1. _____

2. _____

3. _____

4. _____

OBJECTIVE 4

Select from a list guidelines for preparing for medical emergencies. Write an "X" in the blank beside each guideline.

_____1. Know the location(s) of emergency telephone numbers posted in your facility.

_____2. Watch for the planned reaction and for possible side effects of medication administered to individual residents.

_____3. Report and record your interpretation of any signs or symptoms you observe.

_____4. Know the proper procedures to follow and the persons to contact if a resident has refused medication, or if a dose has been missed.

_____5. Know how to respond to possible emergency situations with individual residents before they happen.

OBJECTIVE 5

Distinguish among types of medical emergencies according to their signs, symptoms, and treatment. For each of the following signs, symptoms, or treatments, write "A" for allergies, "U" for urticaria (hives), "AX" for anaphylaxis, or "HS" for drug hypersensitivity.

_____1. Nasal congestion

_____2. Make sure that the resident is transported to a hospital emergency room *as soon as possible*.

_____3. Make sure that the resident's physician is called before a repeated dose of the possible allergen is administered.

_____4. Feeling of coming doom; fright

_____5. Signs and symptoms vary from mild, local symptoms such as redness, swelling, and itching to severe disorders such as asthma, anemia, or anaphylaxis

_____6. Tearing

_____7. Watch for the planned reaction and for possible side effects of medication administered to individual residents.

_____8. Raised and distinct marks on the skin, with a rounded or flat top, with surrounding redness

_____9. Educate the resident to recognize and immediately report any signs of an allergic reaction

_____10. Sudden physical distress (usually within 45 minutes of exposure to an allergen)

OBJECTIVE 1

1. b
2. d
3. e
4. a
5. c

OBJECTIVE 2

In any order:

- Drug is not adequately absorbed into the bloodstream
- Drug is not activated
- Potential side effects

OBJECTIVE 3

Any four (4) of the following:

- Supervisor's name and telephone number
- RN consultant's name and telephone number (if appropriate)
- Physician's name and telephone number (where appropriate)
- Poison Control Center telephone number
- Fire department and ambulance service telephone numbers
- Area hospitals' telephone numbers
- Law enforcement agency telephone numbers

OBJECTIVE 4

1, 2, 4, 5

OBJECTIVE 5

1. A
2. AX
3. A
4. AX
5. HS
6. A
7. HS
8. U
9. HS
10. AX

OBJECTIVE SHEET

CHART MEDICATION ADMINISTRATION AND RESIDENT CARE 6

INTRODUCTION

The main purpose of charting is to communicate information about each resident, in writing. This information is used by the MAT, and others, to provide appropriate care to each resident. If you make a mistake in charting, then the resident may not receive the proper care by the next care provider. Charting results in a permanent, legal record of each resident's condition, the care provided, and the resident's response to care (including medication administration).

This unit presents general information about charting. Your facility may have specific policies about the contents of resident records, who has access to these records, and how to chart required information.

UNIT OBJECTIVE

After completing this unit, you will be familiar with common mistakes in charting and will reinforce your ability to correctly chart medication administration and resident care. You will demonstrate these competencies by completing the Written Test with a minimum of eighty-five percent (85%) accuracy.

PREREQUISITES

Before studying this unit, you should have successfully completed the *Medication Administration Technician* training program.

SPECIFIC OBJECTIVES

After completing this unit, you should be able to

1. Give benefits of charting.
2. Select from a list common mistakes in charting.
3. Interpret standard abbreviations and symbols used in charting.
4. Select from a list general guidelines for charting.
5. List information needed to correctly chart the administration of medication.
6. Select from a list guidelines for documenting the effects of medication.

PREPARATION

- Order additional materials to supplement this unit.
  - — Sample charts or "resident's logs."
- Review the unit and plan your presentation:
  - — Estimate the amount of material that can be covered in each class session.
  - — Identify objectives that you can supplement with other resources.
  - — Invite guest speakers in advance.
- Design transparencies and handouts to reinforce the objectives in each unit, to provide additional information, or to facilitate in-class activities.

DELIVERY

Objective 1

- Discuss *how* charting leads to each given benefit.
- Introduce Supplement 1.
- Add other benefits to those listed.

Objective 2

- Using a sample chart or "resident's log," demonstrate each mistake.
- Give examples of *objective* versus *subjective* entries.

Objective 3

- Review the abbreviations and symbols.
- Ask students for other abbreviations and symbols in use at their facility.

Objectives 4 through 6

- Discuss the importance of each guideline.

- Discuss Supplement 2.

- Using Handout 1, provide students with information needed to complete the "resident's log." Ask each student to complete the log, then discuss *your* example (completed).

EVALUATION

Written Test

- Give the Written Test soon after presenting the unit.

- Remind students throughout your presentation that the questions and required performance on each Written Test match the Specific Objectives stated at the beginning of the unit and the objectives discussed in the unit.

- Review individual and group performance in order to evaluate teaching methods. Adjust your approach as needed.

UNIT REFERENCES

- Curriculum and Instructional Materials Center. *Medication Administration Technician*. Oklahoma Department of Vocational and Technical Education. Stillwater, Oklahoma. 1989.

Patient		Admission Number	Home Number
Attending Physician	Phone	Admission Date	
Allergies/Diet		Current Date	
STAFF'S SIGNATURES AND INSTRUCTIONS ON REVERSE SIDE			

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

This area for Special Instruction

	Initials	STAFF'S SIGNATURE		Initials	STAFF'S SIGNATURE	INDICATE INJECTION SITE WITH APPROPRIATE NUMBER
1			8			1 Buttocks (Gluteous) Left
2			9			2 Buttocks (Gluteous) Right
3			10			3 Arm (Deltoid) Left
4			11			4 Arm (Deltoid) Right
5			12			5 Thigh (Quadraceps) Left
6			13			6 Thigh (Quadraceps) Right
7			14			7 Abdomen Left
						8 Abdomen Right

Date	Hour	MEDICATION & DOSAGE	Route	REASON	RESULT OR RESPONSE	Hour	SIGNATURE

R — Refused
H — Held at Doctor's Request
A — Resident out of Facility
O — Resident out of Medication

W — Resident at Work
DC — Discontinue
WEIGHT BLOOD PRESSURE

HANDOUT - MAT UPDATE
5/6

INFORMATION SHEET	CHART MEDICATION ADMINISTRATION AND RESIDENT CARE 6

OBJECTIVE 1 **Give benefits of charting.**

BENEFITS TO THE RESIDENT

- Charting helps each resident receive *consistent and appropriate care* from the MAT or other care provider.
- Charting helps insure that a resident requiring medication receives the correct medication, the correct dosage, and the correct administration of the medication.

BENEFITS TO THE MAT

- Charting helps the MAT provide appropriate care by communicating to the MAT the care given to each resident, and the resident's response.
- Charting supports the MAT by providing a legal record that the proper medication was given (administered) properly and that the MAT complied with all rules, regulations, and requirements.

OBJECTIVE 2 **Select from a list common mistakes in charting.**

- Forgetting to chart information

  NOTE: A court may assume that medication was not *administered* if it was not *charted*.

- Charting information late

  NOTE: You might forget important information if you fail to chart it promptly.

- Failing to be specific
- Recording your personal opinions

  NOTE: Recording your personal opinions about a resident can affect the care given to that resident. Another MAT or other staff member could be influenced by your recorded opinion and develop the wrong attitude about the resident.

- Using the wrong abbreviations

CAUTION

Charting the wrong abbreviation can seriously threaten the health of the resident.

- Writing poorly

EXAMPLE: Writing that cannot be read by other staff members; using the wrong word or misspelling words

- Correcting errors improperly

EXAMPLE: Erasing a mistake; scratching out a mistake

- Signing improperly

CAUTION

Forgetting to sign your documentation, or failing to sign your name clearly, can create questions about who is responsible for the charting.

OBJECTIVE 3 **Interpret standard abbreviations and symbols used in charting.**

ABBREVIATION OR SYMBOL	MEANING
aa, $\overline{aa}$	of each
ac	before meals
ad lib	as desired
AM, am	morning
amp	ampule
amt	amount
aq	water
bid	twice a day
$\overline{c}$	with
cap	capsule
dil	dilute
DC, disc	discontinued
elix	elixir
et	and
ext	extract
fl, fld	fluid

ABBREVIATION OR SYMBOL	MEANING
(G)	generic name
h, hr	hour
H	hypodermic
hs, HS	hour of sleep
IM	intramuscular
IV	intravenous
Ⓛ	left
mEq	milliequivalent
noc, noct, N	night
NKA	no known allergies
NPO, np	nothing by mouth
NS, N/S	normal saline
OD	right eye
OS	left eye
os	mouth
OU	both eyes
p̄	after
P.E.	Physical examination
per, /	by means of
PM, pm	after noon
po. PO, per os	by mouth
prn, PRN	as necessary
qd	every day
qh	every hour
q2h	every 2 hours
q3h	every 3 hours
qid	four times a day
qod	every other day
qs	quantity sufficient
R	rectal
Ⓡ	right
RBC	red blood count
Rx	take
s̄	without
ROM	range of motion
SC, subq	subcutaneous
SOB	shortness of breath
sig	label
SL	sublingual
sol	solution
sos	once, if necessary
sp	spirits
S/S	signs and symptoms

ABBREVIATION OR SYMBOL	MEANING
stat	immediately
supp	suppository
Sx	symptoms
syr	syrup
(T)	trade name
tab	tablet
tid	three times a day
tinct, tr	tincture
T,P,R	temperature, pulse, respiration
Tx	treatment
U, u	unit
U/A	urinalysis
ung	ointment
VS	vital signs
WBC	white blood count
W/C	wheelchair
>	greater than
<	less than
↓	decrease
↑	increase
♀	female
♂	male

OBJECTIVE 4 **Select from a list general guidelines for charting.**

The following guidelines are general. You must be familiar with the policies of your facility that relate to charting and resident records.

- Use the right forms.
- DOCUMENT *YOUR OWN ACTIONS* ONLY.

  NOTE: Never chart for someone else. You are responsible for starting and finishing a procedure.

- Chart the administration of medication *within one (1) hour.*

  NOTE: This is a requirement of the State Department of Health in its *Standards and Regulations for Licensure of Residential Care Homes in Oklahoma* and the *Standards and Regulations for Licensure of Group Homes in Oklahoma.* A court might assume that medication was not given if it was not charted.

- Document tasks *as you finish them.*

  NOTE: Never record a task or procedure that has not been completed. Never chart by memory.

- Record only facts.

  NOTE: Do not record personal opinions, judgments, attitudes, or interpretations.

- Print or write clearly.

- Always use ink.

- Use correct spelling, grammar, and punctuation.

- Use only the standard abbreviations approved at your facility.

  CAUTION

  Charting the wrong abbreviation can seriously threaten the health of the resident. Never use a word or abbreviation if you are not sure what it means.

- Be specific.

  EXAMPLE: If a resident refuses a medication, record both (1) the *fact* that the resident refused the medication, as well as (2) the *reason given by the resident* for refusing the medication.

- Complete the information required at your facility:

  — the resident's complete first and last name

  — the complete date of each entry

- — the exact time of each entry, in A.M. or P.M.
- — the name of the medication administered, exactly as written on the medication container
- — the dosage, in amount and frequency
- — the route of administration (oral, rectal, etc.)
- — the resident's response to medications and other treatments
- — other information required by your facility

- Write on every line.

  NOTE: Do not add notes between the lines. Also, do not leave empty spaces; someone else could write in the space after you have signed the record.

- Acknowledge any errors on the form.

  NOTE: Follow the policies at your facility, such as identifying the error in the appropriate location on the form and adding your initials. Never erase an error or make it impossible to read.

- Chart anything left out of an earlier entry as a new entry.

  NOTE: Never back-date or add to information that you charted earlier.

OBJECTIVE 5

List information needed to correctly chart the administration of medication.

NOTE: To correctly document the administration of medication, you must obtain certain information from the medication container or from the doctor's written orders. Regardless of what your forms look like, the following information must be documented on those forms.

- Resident's first and last name
- Name and strength of the medication

  EXAMPLE: 50 mg or 100 mg

- Dosage or amount to be administered
- Route of administration

  EXAMPLE: Oral, inhalation, topical, etc.
- Required daily frequency of administration
- Any special orders about the timing of the administration

  EXAMPLE: Before meals, with food

OBJECTIVE 6

Select from a list guidelines for documenting the effects of medication.

- Know the purpose and the desired effect of each medication.
- Know the response time for desired effects to occur.
- Know any possible side effects of a medication.
- Know any possible interactions of a medication with other medications.

CAUTION

If a resident is seeing more than one doctor, or if more than one pharmacy is used to supply a resident's medication, be especially careful to communicate with the doctor or pharmacist about all medications that the resident is using.

- Report and record the effects that you observe.

  NOTE: Be objective. Describe the changes in the resident's physical condition or behavior *as you observe it*. Avoid labeling the effects yourself.

LEGAL IMPORTANCE OF GOOD CHARTING

Here are three true cases of medical malpractice and how the care givers' own charting provided evidence against them.

1. Oza Mae Rogers died of brain damage 7 days after she was admitted to the hospital for injuries suffered in an accident. In the lawsuit that followed, ROGERS V. KASDAN (1981), the Supreme Court of Kentucky ruled against the doctor and the hospital. The court based its ruling on the patient's medical record: The emergency room records were incomplete, the fluid input-output record was incorrectly tallied, different records contained discrepancies, and several records were illegible and contained incomplete notations.

2. Patricia Maslonka hemorrhaged and died 3 hours after giving birth to her fourth child. In the lawsuit that resulted, MASLONKA V. HERMANN (1980), the patient's medical record was again the determining factor in the court's decision. According to the court's interpretation of the record, two nurses and four doctors had been negligent. The nurses had poorly monitored the patient's vital signs and had failed to communicate the patient's condition.

3. ST. PAUL FIRE AND MARINE INSURANCE CO. V. PROTHRO (1979) involved a lawsuit by a patient named Prothro. After a total hip replacement, Mr. Prothro was injured while being lowered into a Hubbard bath by an orderly. The metal basket holding him collapsed, struck his hip, and reopened his wound. The orderly stopped the bleeding and took Mr. Prothro to his room, where a staff nurse reclosed the wound with surgical tape, but no one documented the incident. Several days later, the wound became infected. Subsequently, the doctor had to remove the hip prosthesis, leaving Mr. Prothro with a permanent limp. Mr. Prothro sued the hospital. The court ruled in his favor and said the determining factor was the absence of crucial information on the chart. This could have helped the doctor and other health-care professionals provide Mr. Prothro with more appropriate care.

From *Nurse's Reference Library: Practices*, Springhouse Corporation, Springhouse, Pennsylvania, 1984. Used with permission.

In court, your charting of medications and treatments can be used as evidence of the quality of care that you provide to your resident. If a resident is injured, the *completeness, consistency, and even legibility of your charting may determine the outcome of a lawsuit.*

Patient: John Smith		Admission Number: #14031	Home Number: 245-4878
Attending Physician: Dr. Jones	Phone Number: 742-4400	Admission Date: 7-30-90	
Diet: General		Current Date: 8-1-90	

ALLERGIES: NKA

STAFF'S SIGNATURES AND INSTRUCTIONS ON REVERSE SIDE

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	39	30	31
Dolobid 250mg one p.o. three times a day	8 AM								→																							
	2 PM								→																							
	8 PM								→																							
Inderal 40mg ÷ p.o. twice A day	8 AM					→																										
													ERROR																			
	8 PM					→																										
Halcion 0.125mg ÷ p.o. at bed time	10 PM																															
Bactrim 80mg two p.o. q 12 hrs for 10 days only	8 AM									→																						
	8 PM									→																						
Tylenol 500mg two p.o. P.R.N pain	P																															
	R																															
	N			X																												

This area for Special Instruction

8-12-90 Charted wrong space. S

SAMPLE COMPLETED CHART

	Initials	STAFF'S SIGNATURE		Initials	STAFF'S SIGNATURE	INDICATE INJECTION SITE WITH APPROPRIATE NUMBER
1	JO	Jane Doe M.A.T.	8			1. Buttocks (Gluteous) Left
2	CJ	Carla Jones M.A.T.	9			2. Buttocks (Gluteous) Right
3	AB	Alice Brown M.A.T.	10			3. Arm (Deltoid) Left
4	PC	Paul Coats M.A.T.	11			4. Arm (Deltoid) Right
5			12			5. Thigh (Quadraceps) Left
6			13			6. Thigh (Quadraceps) Right
7			14			7. Abdomen Left
						8. Abdomen Right

Date	Hour	MEDICATION & DOSAGE	Route	REASON	RESULT OR RESPONSE	Hour	SIGNATURE
8/3	9pm	Tylenol 500mg two tablets	po	headache	good - sleeping	10pm	Carla Jones M.A.T.

R - Refused
H - Held at Doctor's Request
A - Resident out ot Facility
O - Resident out of Medication

W - Resident at Work
DC - Discontinue
WEIGHT: ____ BLOOD PRESSURE: ____

SUPPLEMENT 2 - MAT UPDATE
6 - 18

WRITTEN TEST	CHART MEDICATION ADMINISTRATION AND RESIDENT CARE 6

NAME _____ SCORE _____

OBJECTIVE 1 **Give benefits of charting.**

BENEFITS TO THE RESIDENT

1. _____

_____

_____

2. _____

_____

_____

BENEFITS TO THE MAT

3. _____

_____

_____

4. _____

_____

_____

OBJECTIVE 2 **Select from a list common mistakes in charting.** Write an "X" in the blank beside each charting mistake.

_____1. Forgetting to chart information

_____2. Documenting tasks as you finish them

_____3. Recording your personal opinions

_____4. Recording only facts

_____5. Writing on every line

_____6. Using the wrong abbreviations

_____7. Correcting errors improperly

OBJECTIVE 3 **Interpret standard abbreviations and symbols used in charting.** Fill in each blank.

	ABBREVIATION OR SYMBOL	MEANING
1.	aa	_____
2.	ac	_____
3.	_____	twice a day
4.	_____	right eye
5.	OU	_____
6.	q2h	_____
7.	_____	four times a day
8.	_____	rectal
9.	stat	_____
10.	_____	three times a day

OBJECTIVE 4 **Select from a list general guidelines for charting.** Write an "X" in the blank beside each charting guideline.

_____1. Document your own actions only.

_____2. Chart the administration of medication within four (4) hours.

_____3. Record facts and personal opinions.

_____4. Always use ink.

_____5. Use only the standard abbreviations approved at your facility.

_____6. Write on every other line.

_____7. Acknowledge any errors on the form.

OBJECTIVE 5 **List information needed to correctly chart the administration of medication.**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

OBJECTIVE 6 **Select from a list guidelines for documenting the effects of medication.** Write an "X" in the blank beside each guideline.

_____1. Know the purpose and the desired effect of each medication.

_____2. Label the effects yourself.

_____3. Know any possible side effects of a medication.

_____4. Know any possible interactions of a medication with other medications.

CHART MEDICATION ADMINISTRATION AND RESIDENT CARE 6

OBJECTIVE 1

In any order:

BENEFITS TO THE RESIDENT

- Charting helps each resident receive *consistent and appropriate care* from the MAT or other care provider.
- Charting helps insure that a resident requiring medication receives the correct medication, the correct dosage, and the correct administration of the medication.

BENEFITS TO THE MAT

- Charting helps the MAT provide appropriate care by communicating to the MAT the care given to each resident, and the resident's response.
- Charting supports the MAT by providing a legal record that the proper medication was given (administered) properly and that the MAT complied with all rules, regulations, and requirements.

OBJECTIVE 2

1, 3, 6, 7

OBJECTIVE 3

1. of each
2. before meals
3. bid
4. OD
5. both eyes
6. every 2 hours
7. qid
8. R
9. immediately
10. tid

OBJECTIVE 4

1, 4, 5, 7

OBJECTIVE 5

In any order:

- Resident's first and last name
- Name and strength of the medication
- Dosage or amount to be administered

- Route of administration
- Required daily frequency of administration
- Any special orders about the timing of the administration

OBJECTIVE 6 1, 3, 4